

CERTIFICATE OF DEATH

Reg. Dist. No. 21

7858

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i>				c. LENGTH OF STAY IN 1b <i>1 day</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Anne Arundel General</i>				e. STREET ADDRESS <i>5122 Craig Ave</i>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Eva Kelly Adams</i>				4. DATE OF DEATH Month Day Year <i>August 4 1956</i>			
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Nov 3, 1883</i>	
9. AGE (In years last birthday) <i>72</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>			
13. FATHER'S NAME <i>Albert Gumpman</i>				14. MOTHER'S MAIDEN NAME <i>Susan FARRITELL Itzel</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>578-03-43403</i>			
17. INFORMANT <i>John Adams</i>				Address <i>5122 Craig Ave</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Cardiac Failure</i> <i>422.2</i> DUE TO <i>Chronic Myocarditis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>-</i> DUE TO (c) <i>-</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>-</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <i>8/4</i> , 19 <i>56</i> , to <i>8/4</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>7/14</i> , 19 <i>56</i> , and that death occurred at <i>3:30</i> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>E. J. Lankford (M.D.)</i>				ADDRESS (Street, city or town, state) <i>Eastport Md.</i>			
PHYSICIAN'S NAME (Type) <i>E. J. Lankford</i>				DATE SIGNED <i>7/4/56</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8/7/56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Pikesville, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Lickner & Sons</i>				ADDRESS <i>Baets. 17 Md.</i>		24a. REG'D BY REGISTRAR <i>Aug 7, 1956</i>	
24b. REGISTRAR'S SIGNATURE <i>Wm. J. French</i>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, at removal, and in any event within 72 hours after death.

BUREAU V. F.

1956 8 976

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7883

CERTIFICATE OF DEATH

07830

Reg. Dist. No. 24

1. PLACE OF DEATH a. COUNTY <u>GA Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>GA Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ferndale</u>		c. LENGTH OF STAY IN 1b <u>40 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ferndale GA Co Md.</u>	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Francis</u> Middle <u>Amiech</u> Last		4. DATE OF DEATH <u>Aug</u> Month <u>28</u> Day <u>1956</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 18-1889</u>
9. AGE (In years, last birthday) <u>67</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ferdinand Amiech</u>		14. MOTHER'S MAIDEN NAME <u>Augusta Plusen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>John Amiech Jr</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Bladder - (metastatic)</u> <u>181X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Haemorrhage from bowel</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs - 4 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb - 1956</u> to <u>Aug 28</u> , 1956 that I last saw the deceased alive on <u>Aug 28</u> , 1956, and that death occurred at <u>5:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Chas. L. Ball Jr.</u>		ADDRESS (Street, city or town, state) <u>Md</u> DATE SIGNED <u>8/28/56</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug 31-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glen Burne</u>	22d. LOCATION (City, town, or county) (State) <u>GA Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard A Frank</u> ADDRESS <u>Glen Burne Md</u>		24a. REC'D BY REGISTRAR <u>L. J. DeAlba</u> DATE <u>Aug 30-56</u>	
24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

BUREAU V. 1

JUN 21 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7884

CERTIFICATE OF DEATH

07831 21
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Maryland</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waterbury</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>Addie Pauline Aulton</u>				4. DATE OF DEATH Month <u>8</u> Day <u>31st</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-18-1927</u>	
9. AGE (In years last birthday) <u>28</u> yrs.		IF UNDER 1 YEAR Months <u>12</u> Days <u>13</u> Hours <u>15</u> Min.		IF UNDER 24 HRS. Months <u>12</u> Days <u>13</u> Hours <u>15</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Waterbury, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Richard Aulton</u>				14. MOTHER'S MAIDEN NAME <u>Cathrine Hall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, per: (b) unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Cathrine Aulton, Waterbury, Md</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Broncho Pneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>8/27/56</u> , 19 <u>56</u> , to <u>8/31/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8/31/56</u> , 19 <u>56</u> , and that death occurred at <u>12:50 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. L. Richardson</u> M.D. <u>110-clay St. Annapolis, Md</u> DATE/SIGNED <u>9/1/56</u>							
PHYSICIAN'S NAME (Type) <u>R. L. Richardson, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>9-2-56</u>		<u>Town Wesley</u>		<u>Waterbury, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, II - Annapolis, Md</u> ADDRESS				24a. REC'D BY REGISTRAR <u>1556</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Tom J. French</u>	

BUREAU V. 3.

SEP 7 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VS AIS (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
7885									
Name: Film G-201 8-9-56.									
CERTIFICATE OF DEATH									
Reg. Dist. No. 07832 28									
1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL Crownsville MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville			c. LENGTH OF STAY IN 1b 10yrs. 6mo. 1days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington, Maryland				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lucinda			First Middle Last (Bonds) Barnes		4. DATE OF DEATH Month 8 Day 8 Year 19 56				
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 12-1866		9. AGE (In years last birthday) 90? yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unascertained		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Mississippi			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Henry Levi				14. MOTHER'S MAIDEN NAME Lavina Levi					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. -----		17. INFORMANT Hospital Records Crownsville State Hospital Crownsville, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senile Arteriosclerosis DUE TO (c) _____									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-25 , 19 36 , to 8-8-56 , 19 56 , that I last saw the deceased alive on 8-8-56 , 19 56 , and that death occurred at 6:30 a.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Maryland DATE SIGNED 8-8-56									
ACTUAL SIGNATURE Ludwig Benedict, M. D.				M.D. Crownsville, Maryland 8-8-56					
PHYSICIAN'S NAME (Type) Ludwig Benedict, M. D.									
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)			
Burial		8/10/56		mt auburn		Baltimore, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Marshall P. Hayes				ADDRESS 638 N. GILMORT ST. BALTIMORE		24a. REC'D BY REGISTRAR Aug. 9, 1956		24b. REGISTRAR'S SIGNATURE H. M. Joyce	

2

1

BP

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to the quality of the scan.

BUREAU V. 1

AUG 10 1956

RECEIVED

Handwritten signature and date at the bottom of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07833

CERTIFICATE OF DEATH

7886

Reg. Dist. No.

24

1. PLACE OF DEATH a. COUNTY Anne Arundel Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Riviera Beach				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Glen Burnie 502 New Jersey Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First PERRY Middle George Last BOOTH				4. DATE OF DEATH Month August Day 18 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 1, 1922		9. AGE (In years last birthday) 34 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Maryland Drydock		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Creed Booth				14. MOTHER'S MAIDEN NAME Ollie J. Harris			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. 235-20-4707		17. INFORMANT Mrs. Thelma R. Booth Address 815 Stoll St. Baltimore Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH CAUSED BY IMMEDIATE CAUSE (a) 581.1 DUE TO overdose of wine Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) chronic alcoholism DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 1, 1956 to Aug 17 1956 , that I last saw the deceased alive on Aug 17, 1956 , and that death occurred at 8 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Philip W. Keister				ADDRESS (Street, city or town, state) 302 PATAPSCO AVE		DATE SIGNED 8/18/56	
PHYSICIAN'S NAME (Type) PHILIP W. KEISTER							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 8/18/56		22c. NAME OF CEMETERY OR CREMATORY Stringtown, Cemetery		22d. LOCATION (City, town, or county) (State) Belington, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Sons - Balto. 17, Md.				24a. REC'D BY REGISTRAR 21 1956		24b. REGISTRAR'S SIGNATURE L. J. Dealy	

CERTIFICATE OF DEATH

BUREAU Y. S.

AUG 21 1956

RECEIVED

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7859

CERTIFICATE OF DEATH

07834

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o STATE b. COUNTY Washington, D. C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ANNE ARUNDEL GENERAL HOSPITAL		d. STREET ADDRESS 5425 Conn. Ave. N. W. Apt. #202	
3. NAME OF DECEASED (Type or print) First Middle Last EDNA C. BOWYER		4. DATE OF DEATH Month Day Year AUGUST 11 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 7. 1888
9. AGE (In years lost birthday) 68 yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School teacher		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Jessie Thomas Carr		14. MOTHER'S MAIDEN NAME Clara Blanche Fagan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Miss Jessie B. Carr		Address 5425 Conn. Ave. N. W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Centr myocardial infarction</u> 4 a.m. / DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery sclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 16 hrs. many yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10 AUGUST, 1956, to 11 Aug., 1956, that I last saw the deceased alive on 11 August, 1956, and that death occurred at 11:25 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 90 CATHEDRAL ST., ANNAPOLIS, MARYLAND 8/11/56			
ACTUAL SIGNATURE John L. Hedeman		M.D. 90 CATHEDRAL ST., ANNAPOLIS, MARYLAND 8/11/56	
PHYSICIAN'S NAME (Type) JOHN L. HEDEMAN, M. D.			
22a. BURIAL, CREMATION, REMOVAL Cremation	22b. DATE THEREOF 8/14/56	22c. NAME OF CEMETERY OR CREMATORY Lee's Crematory	22d. LOCATION (City, town, or county) (State) Washington, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE J. Williams		ADDRESS 300 1st St. N.E. Washington D.C.	
24a. REC'D BY REGISTRAR DATE AUG 15 1956		24b. REGISTRAR'S SIGNATURE Wm J. French	

RECEIVED

JUG 15 1950

15 JUL 1950

15 JUL 1950
J. Edgar Hoover
U. S. Department of Justice

7887

CERTIFICATE OF DEATH

Reg. Dist. No.

24

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY EDL.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena Md.				c. LENGTH OF STAY IN 1b 15Yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 6 Route #61 Harlem Ave				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena			
f. STREET ADDRESS Harlem Ave Box #6				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Albert Middle Brown Last 				4. DATE OF DEATH Month 8 Day 8 Year 19 56			
5. SEX Male	6. COLOR OR RACE Col	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday) 84 yrs		IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY In General		11. BIRTHPLACE (State or foreign country) Calvert Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Washington Brown				14. MOTHER'S MAIDEN NAME Mary Lizzie Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Edith Coefield		Address Same as Above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute bronchopneumonia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) arteriosclerotic cardio-vascular disease DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 2 days not known	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 2, 1956 to August 8, 1956 , that I last saw the deceased alive on August 8, 1956 , and that death occurred at 7:45 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE R.M. McLaughlin M.D.				ADDRESS (Street, city or town, state) Pasadena, Md.		DATE SIGNED Aug 8, 1956	
PHYSICIAN'S NAME (Type) R.M. McLaughlin, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-11-56		22c. NAME OF CEMETERY OR CREMATORY St Stevens Cem		22d. LOCATION (City, town, or county) (State) Edgemere Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Elroy O. Wilson - 1000 Sontly Ave				24a. REC'D BY REGISTRAR DATE 8/14/56		24b. REGISTRAR'S SIGNATURE L.J. Sealby	

RECEIVED

AUG 15 1956

BUREAU V. S.

7888

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ANNE ARUNDEL CROWNSVILLE MARYLAND				STATE Maryland COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Crownsville				CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State				STREET ADDRESS (If rural give location) 2322 Pennsylvania Avenue			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Alexander E. Brown				4. DATE OF DEATH (Month) (Day) (Year) 8 17 19 56			
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, married	8. DATE OF BIRTH 4-15-91	9. AGE last birthday 65 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter			10b. KIND OF BUSINESS OR INDUSTRY —●—●—●—●—●—	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Brown				14. MOTHER'S MAIDEN NAME Rebecca Gray Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) — — — — —			16. SOCIAL SECURITY NO. 215-16-6260		17. INFORMANT & ADDRESS Hospital records		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Acute myocardial failure							
ANTECEDENT CAUSE(S) DUE TO (B) Myocardial Infarct							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) Hypertensive cardiovascular disease, Senile							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Arteriosclerosis.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 5-9-1956, to 8-17-1956, that I last saw the deceased alive on 8-17-1956, and that death occurred at 10:05 a.m. from the causes and on the date stated above.							
SIGNATURE Lionel McHenry Mapp				Crownsville State		DATE SIGNED 8-17-56	
M.D. Lionel McHenry Mapp, M.D.				ADDRESS (Street, city, town, state)			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 8-22-56		NAME OF CEMETERY OR CREMATORY Arlington National		LOCATION (City, town, or county) (State) Baltimore Md	
24. REC'D BY REGISTRAR DATE 8-21-1956		REGISTRAR'S SIGNATURE F. M. Jones		25. FUNERAL DIRECTOR'S SIGNATURE Lionel McHenry Mapp		ADDRESS Baltimore	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 4 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

BUREAU V. E.

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AUG 21 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director on page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7863

CERTIFICATE OF DEATH

07837

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <u>Anne Arundel General</u>				d. STREET ADDRESS <u>General Highway</u>			
3. NAME OF DECEASED (Type or print) <u>Charles Milton Brown</u>				4. DATE OF DEATH <u>August 22 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 19, 1911</u>	
9. AGE (In years last birthday) <u>44</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Station Operator</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles M. Brown</u>				14. MOTHER'S MAIDEN NAME <u>Clara Hohlbein</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>Dorothy V. Brown</u>		Address <u># 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis generaliz'd</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>6 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED [Enter nature of injury in Part I or Part II of item 18.]			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Jan 10, 1956</u> to <u>Aug 22, 1956</u> , that I last saw the deceased alive on <u>8-20-1956</u> and that death occurred at <u>9:00 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James R. Martin</u>				ADDRESS (Street, city or town, state) <u>Annapolis, Md.</u>			
PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u>				DATE SIGNED <u>8/23/56</u>			
22a. BURIAL, CREMAT. OR REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-25-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Layton Sons</u>				ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>U. D. Smith</u>	
				DATE <u>8/24/56</u>			

W. A. 111111

1956



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7889

CERTIFICATE OF DEATH

078388

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville				c. LENGTH OF STAY IN 1b Mayo			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sanns Nursing Home				d. STREET ADDRESS Mayo			
3. NAME OF DECEASED (Type or print) First ROBERT Middle WILSON Last CARR				4. DATE OF DEATH Month AUGUST Day 19 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 6, 1866		9. AGE (In years last birthday) 90 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 19 Days 19 Hours 56 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Mt Zion, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel J. Carr				14. MOTHER'S MAIDEN NAME Margaret Owens			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---		17. INFORMANT Mr Samuel J. Carr - Son- Edgewater, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Pulmonary Edema DUE TO Chronic Congestive failure DUE TO Arteriosclerotic CVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 2-3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/> WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. --- p. m. ---				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) --- (County) --- (State) ---				20g. (City or town) --- (County) --- (State) ---			
21. I certify that I attended the deceased from --- , 19 --- , to --- , 19 --- , that I last saw the deceased alive on --- , 19 --- , and that death occurred at 5:15 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Frank M. Shipley M.D.				ADDRESS (Street, city or town, state) --- DATE SIGNED 8/20/56			
PHYSICIAN'S NAME (Type) Frank M Shipley MD 63 College Ave. Annapolis, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-21-56		22c. NAME OF CEMETERY OR CREMATORY Mayo Memorial Cemetery		22d. LOCATION (City, town, or county) (State) Mayo, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOPKINS FUNERAL HOME				ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR AUG 22 1956	
				24b. REGISTRAR'S SIGNATURE H. M. Joyce			

MEDICAL CERTIFICATION

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. AIR FORCE

9561 20 571

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7890

CERTIFICATE OF DEATH

07839

Reg. Dist. No. 24

1 PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Arnold</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Dividing Creek</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph Ceska</u>		4. DATE OF DEATH Month Day Year <u>8 - 22 1956</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/12/65</u>
9. AGE (In years last birthday) <u>91</u> yrs		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gardener</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Czech</u>	
11. BIRTHPLACE (State or foreign country) <u>Czech</u>		12. CITIZENSHIP OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph Ceska</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>none</u>	
17. INFORMANT <u>Daughter Mrs Mary Snyder</u>		Address <u>Div. Creek</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Senile arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1955</u> , 19... to <u>1956</u> , 19... that I last saw the deceased alive on <u>8-21-56</u> , 19... and that death occurred at <u>12 noon</u> M, from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Robert R. Hahn</u> M.D.		ADDRESS (Street, city or town, state) <u>Severna Park MD</u> DATE SIGNED <u>8-22-56</u>	
PHYSICIAN'S NAME (Type) <u>Robert R. Hahn</u>		M.D. <u>MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug 27, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Belair Rd.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles O. Schumacher</u>		ADDRESS <u>2601-03-05 E. Madison St.</u>	
24a. REC'D BY REGISTRAR <u>8/24/56</u>		24b. REGISTRAR'S SIGNATURE <u>Louis J. DeAlba</u>	

S A DYING

9501

1012

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7861

CERTIFICATE OF DEATH

07840

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>26 Murray Avenue</u>		d. STREET ADDRESS <u>26 Murray Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Effie W. Chaney</u>		4. DATE OF DEATH <u>August 31 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 2, 1889</u>
9. AGE (in years, last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Wortz</u>		14. MOTHER'S MAIDEN NAME <u>Flora Morrison</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Dr. R. Gardiner Chaney</u>		Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARCINOMA OF BREAST, METASTATIC</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 YRS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CARCINOMA OF COLON</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8/24</u> , 19 <u>56</u> to <u>8/31</u> , 19 <u>56</u> that I lost s/he the deceased alive on <u>8/31</u> , 19 <u>56</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward S. Beck</u> M.D.		ADDRESS (Street, city or town, state) <u>41 Southport Ave Annapolis Md.</u>	
PHYSICIAN'S NAME (Type) <u>EDWARD S. BECK</u>		DATE SIGNED <u>9/1/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-3-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Anne's</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR <u>9/4/56</u>		24b. REGISTRAR'S SIGNATURE <u>J. J. Douch</u>	

BUREAU V. S.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7891

CERTIFICATE OF DEATH

Reg. Dist. No.

28

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville	c. LENGTH OF STAY IN 1b 2yrs. 4mos. 26days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital.		d. STREET ADDRESS 735 W. Dover Street	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First John Middle William Last Clowney		4. DATE OF DEATH Month 8 Day 26 Year 19 56	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/17/43
9. AGE (In years lost day) 13 yrs		IF UNDER 1 YEAR Months — Days —	IF UNDER 24 HRS. Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never employed		10b. KIND OF BUSINESS OR INDUSTRY — — —	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME Joseph Clowney	
14. MOTHER'S MAIDEN NAME Elizabeth Clowney		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. — — —		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 4-7ix DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mental Deficiency		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/31 , 19 54 , to 8/26 , 19 56 , that I last saw the deceased alive on 8/26 , 19 56 , and that death occurred at 4:50p.m. , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>[Signature]</i>		ADDRESS (Street, city or town, state) Crownsville, Md.	
PHYSICIAN'S NAME (Type) L. Benedict		DATE SIGNED 8/27/56	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>		24a. REC'D BY REGISTRAR AUG 30 1956	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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AUG 31 1956

BUREAU V. 2

7862

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis,		c. LENGTH OF STAY IN 1b 17 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		d. STREET ADDRESS Edgewater	
3. NAME OF DECEASED (Type or print) First RACHEL Middle ELLEN Last COLLINSON		4. DATE OF DEATH Month August Day 30 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 12, 1889
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months 67 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Perry Leatherbury		14. MOTHER'S MAIDEN NAME Mary E. Simmons	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. Thomas Edward Collinson-Husband- same as #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Common Thrombosis 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction DUE TO (c) Stenocardia			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 14 yrs 1 yr.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 0 a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/4/56 19 56 to 8/30/56 19 56 , that I last saw the deceased alive on 8/30/56 19 56 , and that death occurred at 1504 M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Albert L. Anderson		ADDRESS (Street, city or town, state) 44 Longwood Rd. Annapolis, Md.	
PHYSICIAN'S NAME (Type) Albert L. Anderson		DATE SIGNED 8/30/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF September 1, 56	
22c. NAME OF CEMETERY OR CREMATORY All Hallows Cemetery		22d. LOCATION (City, town, or county) (State) Birdsville, Anne Arundel, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME		24a. REC'D BY REGISTRAR DATE 9/4/56	
24b. REGISTRAR'S SIGNATURE J. O. O'Connell			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician's office. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No.

7863

1 PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. C. General Hospt.</u>		d. STREET ADDRESS <u>22 Maryland Ave</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Florence Cunningham</u>		4 DATE OF DEATH Month <u>8</u> Day <u>13</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 5-18</u> 9. AGE (In years last birthday) <u>81</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>
13. FATHER'S NAME <u>Clinton W. Cunningham</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>4</u>	17. INFORMANT Address <u>Lola C. Faust</u> (2)
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> 4 x 2.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic CVD.</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8/11/56</u> , 1956, to <u>8/13/56</u> , 1956, that I last saw the deceased alive on <u>8/13/56</u> , 1956, and that death occurred at <u>7:00</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank M. Shipley</u> M.D. <u>63 College Ave Annapolis</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>8/14/56</u>	
PHYSICIAN'S NAME (Type) <u>Frank M. Shipley</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>8-15-56</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>St John Church Yard</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u> ADDRESS <u>Annapolis Md</u>		24a. REC'D BY REGISTRAR DATE <u>8/15/56</u>	24b. REGISTRAR'S SIGNATURE <u>V. O. Smith</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 16 1960

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13, 14 File 6202 8-30-56

07844

7892

CERTIFICATE OF DEATH

Reg. Dist. No. 29

1. PLACE OF DEATH a. COUNTY AA Co. Co. MARYLAND			2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn			c. LENGTH OF STAY IN 1b Yrs.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 14 First Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Bernard Middle Dietrich Last Dietrich			4. DATE OF DEATH Month 8 Day 24 Year 19 56		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 1, 1881	9. AGE (In years last birthday) 74 yrs	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY East Bk. Box Co.		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John Dietrich			14. MOTHER'S MAIDEN NAME Fredericka W. Hammer		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Family Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis 450.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from July 17 , 19 56 , to Aug 24 , 19 56 , that I last saw the deceased alive on Aug 21 , 19 56 , and that death occurred at 6:30 P.M. , from the causes and on the date stated above.					
ACTUAL SIGNATURE James N. Cianos M.D.			ADDRESS (Street, city or town, state) 307 Latrobe Bldg Balto 2 Md. DATE SIGNED Aug 24, 1956		
PHYSICIAN'S NAME (Type) JAMES N CIANOS, M.D., F.A.C.S.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/27/56		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.	
22d. LOCATION (City, town, or county) Baltimore, Md.					
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Home 130 E. Fort Ave. #30			24a. REC'D BY REGISTRAR DATE 8/27/56		24b. REGISTRAR'S SIGNATURE Ida M. Whitman



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7893

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>A. A. Co.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Annapolis</i>		c. LENGTH OF STAY IN 1b <i>Rural - Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Crownsville Rd</i>		e. STREET ADDRESS <i>Crownsville Rd</i>	
3. NAME OF DECEASED (Type or print) <i>Sadie Dorsey</i>		4. DATE OF DEATH Month <i>8</i> Day <i>22</i> Year <i>1956</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-24-1908</i>
9. AGE (In years last birthday) <i>48</i> yrs.		10. IF UNDER 1 YEAR Months <i>7</i> Days <i>18</i>	11. IF UNDER 24 HRS Hours <i>24</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Tracy Landing, Md</i>	
11. BIRTHPLACE (State or foreign country) <i>USA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William Dorsey</i>		14. MOTHER'S MAIDEN NAME <i>Christiana Creek</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Year, if unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Sherman Dorsey - Crownsville Rd</i>	
17. INFORMANT <i>Sherman Dorsey - Crownsville Rd</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Broncho Pneumonia</i> <i>441X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Pneumonia</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>August 20, 1956</i> to <i>August 23, 1956</i> , that I last saw the deceased alive on <i>August 22, 1956</i> , and that death occurred at <i>1:25 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>R. L. Richardson</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>110 - Oak St. Annapolis, Md. 8/23/56</i>	
PHYSICIAN'S NAME (Type) <i>William Reese, II - Annapolis, Md</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>8-26-56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Carter's Chapel</i>	22d. LOCATION (City, town, or county) (State) <i>Friendship, Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, II - Annapolis, Md</i>		24a. REC'D BY REGISTRAR DATE <i>8/25/56</i>	24b. REGISTRAR'S SIGNATURE <i>Dr. Frank J. French</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07846

CERTIFICATE OF DEATH

Reg. Dist. No. 21

Items 14, 15: 0205 10-10-56 L

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN TB 1 yr		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS Carver Hall Hotel		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROSCOE A DUNBAR		First Middle Last		4. DATE OF DEATH AUGUST 26, 1956		Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 2, 1899		9. AGE (In years last birthday) 57 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Teacher		10b. KIND OF BUSINESS OR INDUSTRY High School		11. BIRTHPLACE (State or foreign country) Bowers Station, Indiana		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Peter Dunbar				14. MOTHER'S MAIDEN NAME Emma Bowers PARKER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give year or dates of service) Unknown		16. SOCIAL SECURITY NO. 317-0992929		17. INFORMANT Mrs Helen C. Dunbar- Wife- same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs. P	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/26/1956 , to 8/26/1956 , that I last saw the deceased alive on 8/26/1956 , and that death occurred at 10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 8/27/56							
ACTUAL SIGNATURE Frank M. Shipley		M.D. 6					
PRINTED NAME (Type) Frank M. Shipley MD		63 College Ave, Annapolis, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-29-56		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial Cemetery		22d. LOCATION (City, town, county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Don L. Hopping Jr. ADDRESS Hopping Funeral Home Annapolis, Maryland				24a. REC'D BY REGISTRAR DATE 8-29-56		24b. REGISTRAR'S SIGNATURE J. O. Drunch	

RECEIVED

AUG 30 1956

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07847

7894

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 2, Film G201 8-13-56 et

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>C DENTON, MD</u>		c. LENGTH OF STAY IN lb <u>2 YRS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FENTINGHAR PARK, MD</u>		d. STREET ADDRESS <u>1125 Arkansas Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>REESE RD. & MD. 175</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>A.</u> Last <u>Dunning</u>				4. DATE OF DEATH Month <u>August</u> Day <u>5</u> Year <u>1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 8, 1935</u>	
9. AGE (In years last birthday) <u>21</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Soldier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. ARMY</u>		11. BIRTHPLACE (State or foreign country) <u>Pittsburgh, PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>NORMAN MAXWELL DUNNING</u>				14. MOTHER'S MAIDEN NAME <u>CECYLE LASSE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES</u>		16. SOCIAL SECURITY NO. <u>183-26-923</u>		17. INFORMANT Address <u>1125 ARKANSAS AVE. PITTSBURGH 16, PA.</u> <u>MRS. CECYLE DUNNING</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Compound fracture of skull killed</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>instantly</u> (c) <u>stating the underlying cause lost.</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>thrown from auto in accident and killed instantly</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>9:10</u> a.m. <u>8/5</u> 19 <u>56</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>		20f. (City or town) (County) (State) <u>Pt. Geo. 57 Made A.C. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R.M. McLaughlin</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>R.M. McLaughlin, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-6-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. LEBANON</u>		22d. LOCATION (City, town, or county) (State) <u>PITTSBURGH, PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Carter, Jr., Baltimore, Md.</u>				24a. REC'D BY REGISTRAR <u>5 AUG 56</u>		24b. REGISTRAR'S SIGNATURE <u>William L. Saylor, Jr.</u>	

DATE SIGNED

August 5, 1956

BUREAU V. S.

10

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RECEIVED

7895

CERTIFICATE OF DEATH

Reg. Dist. No. 24

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Anne Arundel</i>		STATE <i>MARYLAND</i>		STATE <i>Md.</i>		COUNTY <i>Q. Q.</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Pasadena</i>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Pasadena</i>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Panders Park Rd. Route 2</i>				STREET ADDRESS (If rural give location) <i>Panders Park Rd. Route 2</i>			
3. NAME OF DECEASED (Type or Print) <i>Mary P. Frank</i>				4. DATE OF DEATH (Month) <i>Feb.</i> (Day) <i>28</i> (Year) <i>1956</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>May 29, 1901</i>	9. AGE last birthday <i>55</i> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Harry Russell</i>				14. MOTHER'S MAIDEN NAME <i>P. P.</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>---</i>		17. INFORMANT & ADDRESS <i>Henry W. Frank (Same)</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
176X IMMEDIATE CAUSE (A) <i>Squamous cell carcinoma right</i>				INTERVAL BETWEEN ONSET AND DEATH <i>10-12 months</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Lechia majora and minor and</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <i>metastasis in right inguinal nodes</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <i>4/28, 1956</i>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>8/24, 1956</i> to <i>8/28, 1956</i> , that I last saw the deceased alive on <i>8/24, 1956</i> , and that death occurred at <i>1:30 P.M.</i> from the causes and on the date stated above <i>8-28-56</i>							
SIGNATURE <i>Harry Leebee</i>				ADDRESS (Street, city, town, state) DATE SIGNED <i>1226 Homer St Balto 30 Md</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Buried</i>		DATE THEREOF <i>Aug. 31-1956</i>		NAME OF CEMETERY OR CREMATORY <i>Brooklyn Hill Cem</i>		LOCATION (City, town, or county) (State) <i>Brooklyn Md</i>	
24. REC'D BY REGISTRAR <i>L. J. Adkins</i>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <i>G. Howard Evans</i>		ADDRESS <i>1400 S. Charles St Balto 30 Md</i>	

RECEIVED

1961

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07849 28

7896

CERTIFICATE OF DEATH

Reg. Dist. No. ~~100~~

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Md. (Rural)</u>			
c. LENGTH OF STAY IN 1b <u>4 yrs.</u>				d. STREET ADDRESS <u>Crownsville Rd., Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Leslie</u> Middle <u>Frederick</u> Last <u>Green</u>				4. DATE OF DEATH Month <u>August</u> Day <u>30</u> Year <u>1956</u>			
5. SEX <u>4</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years last birthday) <u>39</u> yrs		10. IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Min <u></u>		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>John Green</u>				14. MOTHER'S MAIDEN NAME <u>Viola Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>			
17. INFORMANT <u>David Frederick Crownsville, Md</u> Address <u></u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Peritonitis</u> DUE TO <u>Adeno Carcinoma of the Left Ovary</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>with Metastases to Mesenteric Nodes & Liver</u> DUE TO <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
INTERVAL BETWEEN ONSET AND DEATH <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>May 1956</u> to <u>8/30</u> , 1956, that I last saw the deceased alive on <u>8/29</u> , 1956, and that death occurred at <u>2:00 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. L. Richardson</u> M.D. <u>110 - Clay Street Annapolis, Md</u>				DATE SIGNED <u>9/30/56</u>			
PHYSICIAN'S NAME (Type) <u>R. L. RICHARDSON MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Sept 4, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Carver Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Purcell Geo. Co. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Washington - Sons</u> ADDRESS <u>462 N. St. N.W.</u>				24a. REC'D BY REGISTRAR <u>1530</u>		24b. REGISTRAR'S SIGNATURE <u>L. M. Jayne</u>	

BUREAU V. E.

1910

1910

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07850

7897

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

24

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie				c. LENGTH OF STAY IN 1b 2½ years			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 101 First Avenue S.E.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Thomas Dominic Gaito				4. DATE OF DEATH Month August Day 31st. Year 1956			
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/4/1904	9. AGE (in years) 51	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor at The Westinghouse Elec. Co.				10b. KIND OF BUSINESS OR INDUSTRY Westinghouse Elec. Co.		11. BIRTHPLACE (State or foreign country) Newark, N.J.	
13. FATHER'S NAME Carmen Gaito				14. MOTHER'S MAIDEN NAME Theresa Cindarella			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO 141-07-5615		17. INFORMANT Mrs. Theresa Gaith, (Wife)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH Sudden	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Gustave H. Faubert				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Sept 3-56		22c. NAME OF CEMETERY OR CREMATORY Holy Cross		22d. LOCATION (City, town, or county) (State) North Arlington New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE Edmond A. G. G. G.				24a. REC'D BY REGISTRAR Sept 1, 1956		24b. REGISTRAR'S SIGNATURE L. J. De Alba	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

SEP 4 1900

RECEIVED
SEP 4 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

07851

Reg. Dist. No 27

7898

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort G. G. Meade</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Army Hospital</u>				d. STREET ADDRESS <u>Quarters 4234</u>			
3. NAME OF DECEASED (Type or print) First <u>FRANZ</u> Middle <u>—</u> Last <u>GRASHL</u>				4. DATE OF DEATH Month <u>August</u> Day <u>14</u> Year <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>22 Sept 1884</u>	9. AGE (In years last birthday) yrs. <u>71</u>	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min <u>—</u>		IF UNDER 24 HRS Hours <u>—</u> Min <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> 7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>—</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>14 August, 19 56</u> , to <u>14 August, 19 56</u> , that I last saw the deceased alive on <u>14 August, 19 56</u> , and that death occurred at <u>10:30PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard H. Kosterlitz</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>Fort George G. Meade, Maryland 15 Aug 56</u>			
PHYSICIAN'S NAME (Type) <u>RICHARD H. KOSTERLITZ, CAPT, MD, Fort George G. Meade, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>17 Aug 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Grace Church</u>		22d. LOCATION (City, town, or county) (State) <u>Cismont, Virginia</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simon Funeral Home</u>				ADDRESS <u>Simpton Funeral Home, Glen Burpie, Maryland</u>		24a. REC'D BY REGISTRAR <u>W. L. Saylor</u>	
				DATE <u>15 Aug 56</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Saylor</u> MSC	

RECEIVED
AUG 17 1956
BUREAU V. 8

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

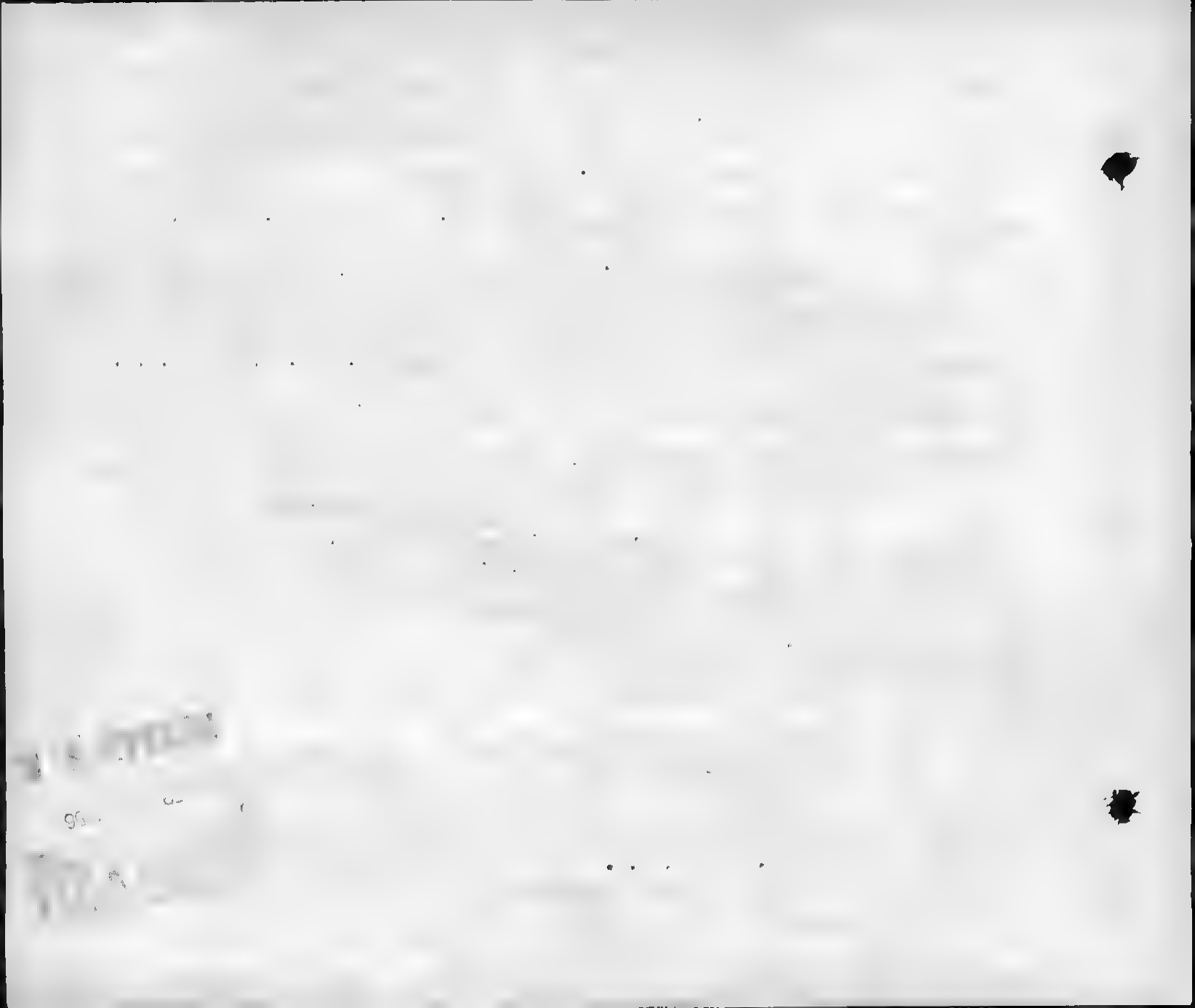
08965
77

Reg. Dist. No.

7899

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel County,</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessup,</u> c. LENGTH OF STAY IN 1b <u>4 mos.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Maryland House of Correction</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>631 W. Lafayette Ave., Balto.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>D.</u> Last <u>GRIFFIN</u>		4. DATE OF DEATH Found <u>8-</u> <u>15</u> <u>19 56</u> Month Day Year		5. SEX <u>Male</u> 6. COLOR OR RACE <u>Colored</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>								
8. DATE OF BIRTH <u>9-16-24</u> 9. AGE (In years last birthday) <u>31</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Dinwiddie Co., Va.</u> 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Daniel Griffin</u> 14. MOTHER'S MAIDEN NAME <u>Martha Morgan</u>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes, give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>230-16-0503</u>		17. INFORMANT <u>Maryland House of Correction Records</u> Address _____								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table style="width: 100%;"> <tr> <td colspan="2"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Undetermined (due to extreme postmortem decomposition)</u> DUE TO </td> <td rowspan="3" style="vertical-align: top;"> INTERVAL BETWEEN ONSET AND DEATH </td> </tr> <tr> <td colspan="2"> (b) <u>Found dead in hay loft of barn</u> DUE TO </td> </tr> <tr> <td colspan="2"> (c) <u>Missing one week</u> </td> </tr> </table>						PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Undetermined (due to extreme postmortem decomposition)</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH	(b) <u>Found dead in hay loft of barn</u> DUE TO		(c) <u>Missing one week</u>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Undetermined (due to extreme postmortem decomposition)</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH										
(b) <u>Found dead in hay loft of barn</u> DUE TO												
(c) <u>Missing one week</u>												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____												
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) _____										
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)								
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .												
ACTUAL SIGNATURE <u>Russell S. Fisher</u>		EXAMINER'S NAME (Type) <u>Russell S. Fisher, M.D.</u>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/17/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u>								
22d. LOCATION (City, town, or county) <u>Baltimore, Maryland</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u>										
24a. REC'D BY REGISTRAR <u>DATE</u>		24b. REGISTRAR'S SIGNATURE <u>Clara Fisher</u>										

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07852

CERTIFICATE OF DEATH

Reg. Dist. No. 27

7900

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Ohio</u>		COUNTY <u>Summit</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Fort G. G. Meade</u>		<u>5 Days</u>		TOWN <u>Dundalk</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u>				STREET ADDRESS (If rural give location) <u>2515 Yorkway 526 Howard Ave.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>LARRY WILLIAM HALL</u>				<u>August 16 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH		9. AGE last birthday	IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>12 August 1956</u>		<u>Yrs.</u>	<u>5</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>None</u>		<u>None</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Leon W. Hall</u>				<u>Kiyoko Hasebe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Father, 2515 Yorkway, Dundalk, Maryland</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				<u>5 days</u>			
IMMEDIATE CAUSE (A) <u>Prematurity</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12 Aug</u>, 19<u>56</u>, to <u>16 Aug</u>, 19<u>56</u>, that I last saw the deceased alive on <u>16 Aug</u>, 19<u>56</u>, and that death occurred at <u>12:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>HERBERT L. NEEDLEMAN, Capt, MC.</u>				DATE SIGNED <u>16 Aug 56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				25. FUNERAL DIRECTOR'S SIGNATURE			
<u>Burial</u>				<u>WM COOK, INC. Baltimore, Maryland</u>			
24. REC'D BY REGISTRAR		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)	
<u>W. L. SAILOR, 1ST LT, MSC</u>		<u>U. S. National Cemetery</u>		<u>Baltimore, Maryland</u>			
DATE <u>17 Aug 56</u>		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS			
		<u>WM COOK, INC. Baltimore, Maryland</u>					

BUREAU V. S.

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REC

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7865 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07853

Reg. Dist. No. 20

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lethion Annapolis				c. LENGTH OF STAY IN 1b Lethion			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle HALL Last HALL				4. DATE OF DEATH Month August Day 19 Year 1956			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 9 1906	
9. AGE (In years last birthday) 50 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Housework		11. BIRTHPLACE (State or foreign country) Bristol Md.	
13. FATHER'S NAME Charles Whittington				14. MOTHER'S MAIDEN NAME Margaret Waters			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute peritonitis due to crushing injury of abdomen Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last, DUE TO (b) Bilateral massive pulmonary atelectasis (c) Auto accident							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto accident					
20c. TIME OF INJURY Hour 4:05 p. m. Month, Day, Year 8/18/56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street		20f. (City or town) (County) (State) Mt. Zion Anne Arundel Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE William V. Lovitt, Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 8/20/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Aug 23/56		22c. NAME OF CEMETERY OR CREMATORY Moses		22d. LOCATION (City, town, or county) (State) Drury Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Hardaway Salisbury				ADDRESS Salisbury		24a. REC'D BY REGISTRAR DATE 8/22/56	
24b. REGISTRAR'S SIGNATURE Caroline				24c. REGISTRAR'S SIGNATURE Caroline			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26



may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07854

07854

Reg. Dist. No. 21

7866

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>A. A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. A. General Hosp</u>		d. STREET ADDRESS <u>32 Indian Landing</u>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Hall</u> Last <u>Hall</u>		4. DATE OF DEATH Month <u>8</u> Day <u>19</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-24-1887</u>
9. AGE (In years, last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR: Months <u>6</u> Days <u>9</u> Hours <u>19</u> Min. <u>56</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-Employed</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wesley Hall</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Emnis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-12-9184</u>	
17. INFORMANT <u>Margaret Hall</u>		Address <u>Millersville, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Arteriosclerotic Vascular Disease</u> DUE TO (c) <u>Obesity</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8/11/56</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/11</u> , 19 <u>56</u> , to <u>8/19</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8/19</u> , 19 <u>56</u> , and that death occurred at <u>8:20</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Maurice F. Klawns</u> M.D.		ADDRESS (Street, city or town, state) <u>Annapolis, Md</u>	
PHYSICIAN'S NAME (Type) <u>MAURICE F. KLAWS</u>		DATE SIGNED <u>8/19/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-22-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>		22d. LOCATION (City, town, or county) (State) <u>Waterbury Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, II</u>		ADDRESS <u>Annapolis, Md</u>	
24a. REC'D BY REGISTRAR <u>1956</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. J. Fenchy</u>	

BUREAU N. A.

JUG 22 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07855

7901

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Baltimore City</i> b. COUNTY <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Crownsville</i>		c. LENGTH OF STAY IN 1b <i>11 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Windsor Park Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Emma</i> Middle <i>Harris</i> Last <i>Harris</i>		4. DATE OF DEATH Month <i>8</i> Day <i>25</i> Year <i>1956</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>N</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 20, 1900</i>
9. AGE (In years last birthday) <i>56</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <i>2</i> Days <i>5</i> Hours <i>15</i> Min <i>00</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>domestic</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Robert Sprout</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <i>hospital record</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypostatic Pneumonia</i> <i>443x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertensive Cardio-vascular Disease</i> DUE TO (c) <i>11 yrs</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>rt. Hemiparesis, Occipital ulcers</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1-1-56</i> to <i>8-25-56</i> , that I last saw the deceased alive on <i>8-25-56</i> , and that death occurred at <i>9:55 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Heinrich</i> M.D.		ADDRESS (Street, city or town, state) <i>Crownsville State Hospital</i>	
PHYSICIAN'S NAME (Type) <i>L. BENEDICT</i>		DATE SIGNED <i>8/26/56</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>8/29/56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>mt. Auburn</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Mrs Joseph A. Eirely</i>		24a. REC'D BY REGISTRAR <i>661 W. Bm</i>	24b. REGISTRAR'S SIGNATURE <i>Kathleen M. Joyce</i>

WILLIAM A. S.

1056

1890

BUREAU A. 2.

JG - 1956

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 9 Filed 201 8-10 -56 et

CERTIFICATE OF DEATH

07857

Reg. Dist. No. 54

7903

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>M.D.</u> COUNTY <u>A.A.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>	
CITY OR TOWN <u>Severna Park</u>		LENGTH OF STAY (In this place) <u>16 yrs</u>		STREET ADDRESS <u>604 Riggs Ave</u>		STREET ADDRESS (If rural give location) <u>604 Riggs Ave</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>604 Riggs Ave</u>				HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>604 Riggs Ave</u>			
3. NAME OF DECEASED (Type or Print) <u>Charles Hauck</u>				4. DATE OF DEATH (Month) <u>8</u> (Day) <u>2</u> (Year) <u>1956</u>			
5. SEX <u>M</u>		6. CO. OR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>Sept 30/1872</u>	
9. AGE last birthday <u>83</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Junior</u>		13. FATHER'S NAME <u>Rudolph Hauck</u>		14. MOTHER'S MAIDEN NAME <u>Elsie</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>	
16. SOCIAL SECURITY NO. <u>5-15-10000</u>		17. INFORMANT & ADDRESS <u>Sister: Anna A Reuling</u>		18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		19. DATE OF OPERATION	
IMMEDIATE CAUSE (A) <u>1. Pericardial Hemorrhage</u>		ANTECEDENT CAUSE(S) (B) <u>2. Hypertension</u>		DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>3. Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				21. MAJOR FINDINGS OF OPERATION			
22. I hereby certify that I attended the deceased from <u>8/1956</u> , to <u>8/2-56</u> , 19 , that I last saw the deceased alive on <u>7-28-56</u> , 19 , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.				23. SIGNATURE <u>R. Hauck</u> M.D. <u>Severna Park</u> DATE SIGNED <u>8-2-56</u>			
24. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		25. NAME OF CEMETERY OR CREMATORY <u>LORRAINE PARK</u>		26. LOCATION (City, town, or county) <u>WOODLAWN MD</u>		27. DATE OF OPERATION <u>8/4/56</u>	
28. REC'D BY REGISTRAR <u>1956</u>		29. REGISTRAR'S SIGNATURE <u>L. J. LeBlanc</u>		30. FUNERAL DIRECTOR'S SIGNATURE <u>GEORGE M. BACH</u>		31. ADDRESS <u>52 LYNN HURST ST</u>	



1950

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

07858 21

7867

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>422 Chesapeake Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Robert Lee Hawkins</u>		4. DATE OF DEATH Month <u>8</u> Day <u>3</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-12-1878</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Dennis Murdock</u>		14. MOTHER'S MAIDEN NAME <u>Sue Murdock</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u> </u>	
17. INFORMANT <u>Henry Hawkins - Annapolis, Md</u>		Address <u> </u>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical exam ner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u> </u> , 19 <u> </u> to <u> </u> , 19 <u> </u> , that I last saw the deceased alive on <u> </u> , 19 <u> </u> , and that death occurred at <u> </u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u> </u>		ADDRESS (Street, city or town, state) DATE SIGNED <u> </u>	
PHYSICIAN'S NAME (Type) <u> </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-6-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Annapolis Neck</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Neck Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, II - Annapolis</u>		ADDRESS <u> </u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Mr. J. French</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event, within 72 hours after death.

AUG 5 1956

RECEIVED
JAN 10 1954

RECEIVED
JAN 10 1954

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7868

CERTIFICATE OF DEATH

07859 21

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. B. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cape Arthur (Severna Park)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel Gen. Hosp.</u>				d. STREET ADDRESS <u>209 Huddings ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Herring</u> Last <u>Herring</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>9</u> Year <u>1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 27 - 1874</u>	
9. AGE (In years last birthday) <u>82 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>Germany</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Henry Herring</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Mrs. G. Compton</u>				Address <u>209 Huddings ave. Cape Arthur</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic carcinoma</u> DUE TO (b) <u>—</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>tuberculo-pneumothorax</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>—</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June</u> , 19 <u>55</u> , to <u>August</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>August 9</u> , 19 <u>56</u> , and that death occurred at <u>6 PM</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>90 Catherine St. Baltimore Md.</u> DATE SIGNED <u>8/10/56</u> SIGNATURE <u>John C. Henderson</u> M.D. PHYSICIAN'S NAME (Type) <u>Anne Arundel Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 13 - 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore City Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Donald Francis Gagne</u> ADDRESS <u>—</u>				24a. REC'D BY REGISTRAR <u>Aug 14 1956</u> 24b. REGISTRAR'S SIGNATURE <u>John J. Franchi</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JUG 14 1936
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 are to be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07860

7869

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>AA.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. GENERAL HOSPT</u>				d. STREET ADDRESS <u>154 PRINCE GEORGE ST</u>			
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>S.</u> Last <u>HILL</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>11</u> Year <u>1956</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 24, 1880</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>HENRY SILVER</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET RULLMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u> </u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT Address <u>MRS. MORGAN O. PARLETT</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>20.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>56</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>Aug 11</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Aug 10</u> , 19 <u>56</u> , and that death occurred at <u>11:30</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John M. Taylor</u>				ADDRESS (Street, city or town, state) <u>90 Cathedral St.</u>		DATE SIGNED <u>8/11/56</u>	
PHYSICIAN'S NAME (Type) <u>Annapolis Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		22b. DATE THEREOF <u>8-14-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN M. TAYLOR - SON ANNAPOLIS MD</u>				ADDRESS <u> </u>		24a. REC'D BY REGISTRAR DATE <u>8/13/56</u>	
				24b. REC'D BY REGISTRAR SIGNATURE <u>U. D. D. D.</u>			

RECEIVED
AUG 14 1910
BUREAU V. S.

1

7924 **CERTIFICATE OF DEATH**

Titer 8, Film G201, 8/23/56 bh

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		STATE D. Columbia COUNTY		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY		TOWN	
TOWN Millersville		43 days		STREET ADDRESS (If rural give location)		2445 XV Street, N.W.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sann's Nursing Home.							
3. NAME OF DECEASED (First) (Middle) (Last) John Guthrie Hopkins				4. DATE OF DEATH (Month) (Day) (Year) 8/19/56 19			
5. SEX M.	6. COLOR OR RACE W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) W.	8. DATE OF BIRTH 11/16/56 1854		9. AGE last birthday 101 yrs.		10. IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Financier		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Kilmarnock, Scotland.		12. CITIZEN OF WHAT COUNTRY? ?	
13. FATHER'S NAME Robert Hopkins				14. MOTHER'S MAIDEN NAME Agnes Cuthbertson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Sann's Nursing Home Records			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) General Arteriosclerosis						?	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 7/5/56 to 8/19/56, 19....., that I last saw the deceased alive on 7/27/56, 19....., and that death occurred at 9:45 A.M. from the causes and on the date stated above.							
SIGNATURE <i>Glen Burnie, Md.</i> M.D. Glen Burnie, Md.				DATE SIGNED 8/19/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 8-27-56		NAME OF CEMETERY OR CREMATORY UNION CEMETERY		LOCATION (City, town, or county) (State) KEESBURG, VIRGINIA	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>W. M. Joyce</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>HOPKINS & HIRKLEY</i> GLEN BURNIE, Md.			
DATE							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

BUREAU A. S.

JUN 21 1936

RECEIVED

7905

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>GLEN BURNIE</u>				TOWN <u>27 Marley Neck Rd.</u>		TOWN <u>27 Marley Neck Rd.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>27 Marley Neck Rd.</u>				STREET ADDRESS (If rural give location) <u>Glen Burnie</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>SCPHIA</u> (Middle) <u>HULL</u> (Last)				(Month) <u>Aug</u> (Day) <u>26</u> (Year) <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>F</u>	<u>W</u>	<u>Widow</u>	<u>Feb. 28, 1883</u>	<u>73</u> yrs.	Months <u></u> Days <u></u>	Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housework</u>		<u>own home</u>		<u>Baltimore, Md.</u>		<u>U.S.-A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John C. Seifert</u>				<u>Elizabeth Woolschleger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Walter E. Seifert 3107 Evergreen Balto. Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>CORONARY THROMBOSIS</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO <u>HYPERTENSIVE CARDIOVASCULAR</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Disease. ARTERIOSCLEROTIC</u>							
(C) <u>HEART DISEASE</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Aug. 1955, to Aug. 26, 1956, that I last saw the deceased alive on Aug. 26, 1956, and that death occurred at 8:20 AM, from the causes and on the date stated above.							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Walter E. Seifert</u>		<u>8/29/56</u>		<u>Western</u>		<u>Balto. Md.</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Burial</u>		<u>L. J. Adlberg</u>		<u>W. J. Adlberg</u>		<u>Glen Burnie, Md.</u>	

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

AUG 30 1956

RECEIVED

AUG 30 1956

RECEIVED

Items 4 & 9, 79-63201, 8/22/51 **CERTIFICATE OF DEATH**

Reg. Dist. No. _____

28

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION Crownsville State		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 1615 E. Lombard Street d. STREET ADDRESS 1615 E. Lombard Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lester Jackson		4. DATE OF DEATH Month 8 Day 10 Year 1956	
5. SEX male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-25-19
9. AGE (In years last birthday) 37 1/2 yrs.		10. IF UNDER 1 YEAR Months 0 Days 10 Hours 19 Min. 56	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		12. KIND OF BUSINESS OR INDUSTRY North Carolina	
13. FATHER'S NAME Luther Jackson		14. MOTHER'S MAIDEN NAME Fannie Mackson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 100-1-10000	
17. INFORMANT Hospital Records		Address Hospital Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probably cardiac arrest, due to unknown cause DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 782.4 (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 782.4	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. DEATH WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-9- 19-54 to 9-10- 1956 , that I last saw the deceased alive on 9-10- 1956 , and that death occurred at 1:50 p.m. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Crownsville, Maryland DATE SIGNED 9-10-56	
ACTUAL SIGNATURE L. Benedict		M.D. Crownsville, Maryland	
PHYSICIAN'S NAME (Type) Ludwig Benedict, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-15-56	
22c. NAME OF CEMETERY OR CREMATORY St. Albans		22d. LOCATION (City, town, or county) (State) Brooklyn Md 25	
23. FUNERAL DIRECTOR'S SIGNATURE C. O. Wilson		24a. REC'D BY REGISTRAR 8/14/56	
ADDRESS 1000 Brentley Ave		24b. REGISTRAR'S SIGNATURE H. M. Jones	

BUENAY N. S.

AUG 15 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 2, See: Birth cert. et
CERTIFICATE OF DEATH
 7870

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>City</u>				c. LENGTH OF STAY IN 1b <u>1 Mo.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Annapolis, Md.</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maryland, Glen Burnie</u>			
				d. STREET ADDRESS <u>516 Wimmer Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>William</u> Last <u>JACOBSON</u>				4. DATE OF DEATH Month <u>August</u> Day <u>2</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/2/56</u>		9. AGE (In years last birthday) <u>31</u> yrs	IF UNDER 1 YEAR Months <u>31</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>---</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USN</u>	
13. FATHER'S NAME <u>John Joseph JACOBSON</u>				14. MOTHER'S MAIDEN NAME <u>Susanne Alethea FORD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>---</u> (If yes, give war or dates of service) <u>---</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>USNH, Records</u>		Address <u>---</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Virus pneumonia #192</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>---</u> DUE TO (c) <u>---</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/2/56</u> , 19 <u>56</u> , to <u>8/2/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8/2/56</u> , 19 <u>56</u> , and that death occurred at <u>8.40 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Carl [Signature]</u> M.D.				PHYSICIAN'S NAME (Type) <u>J... Naval Hospital, Annapolis, Md</u> <u>8/3/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Aug 4-56</u>		<u>Holy Cross Cemetery</u>		<u>Brooklyn, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard G. [Signature]</u>				24a. REC'D BY REGISTRAR <u>[Signature]</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

BUREAU V. S.

AUG 5 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07866

7907

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>M.D.</u>		COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>MILLERSVILLE MD</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pasadena</u>		STREET ADDRESS (If rural give location) <u>Pasadena Rd.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS							
3. NAME OF DECEASED (First) (Middle) (Last) <u>Clarence Johnson</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>8 19 1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>Sept 9 1884</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tax Office</u>		11. BIRTHPLACE (State or foreign country) <u>BROOKLYN, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Lenthicuin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Son Milton Johnson</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>1. Leukemia</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>2. Chronic Bilateral Pyelitis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>3. Generalized Arteriosclerosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>4. Parkinsonism</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1954</u> to <u>19 Aug</u>, 19<u>56</u>, that I last saw the deceased alive on <u>18 Aug</u>, 19<u>56</u>, and that death occurred at <u>8:45</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>Robert R. Hobbs</u>		DATE THEREOF <u>Aug-22-56</u>		NAME OF CEMETERY OR CREMATORY <u>Severna Park</u>		LOCATION (City, town, or county) <u>MD</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. M. Joyce</u>		DATE SIGNED <u>8-19-56</u>	
DATE <u>AUG 22 1956</u>		REGISTRAR'S SIGNATURE <u>H. M. Joyce</u>		ADDRESS <u>Stonington, Annapolis, Md.</u>			

RECEIVED

AUG 28 1956

OFFICE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7998 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **07867**

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived; if institution, Residence before admission) a. STATE <u>Maryland</u> COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burton Bay</u>		c. LENGTH OF STAY IN 1b <u>7 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cooperative Fertilizer Service of Baltimore</u>				d. STREET ADDRESS <u>1300 2nd Street Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>L. Hyde Johnson</u>				4. DATE OF DEATH Month <u>August</u> Day <u>27</u> Year <u>1956</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>C.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/22/23</u>	
9. AGE (In years last birthday) <u>32</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lab. Asst.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Sevier County, Tenn.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>James M. Johnson</u>				14. MOTHER'S MAIDEN NAME <u> </u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u>251-20-2889</u>		17. INFORMANT <u>Cooperative Fertilizer Service of Baltimore</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>GUSTAVE H. FAUBERT</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-1-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Western Burial</u>		22d. LOCATION (City) (County) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel W. Sullivan</u>				24a. REC'D BY REGISTRAR <u>Baltimore</u>		24b. REGISTRAR'S SIGNATURE <u>John H. Hutton</u>	

RECEIVED

AUG 30 1956

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <i>A. A.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <i>Ind.</i> b. COUNTY <i>A. A.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Amapolis</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Amapolis</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>A. A. Gen. Hospital</i>				d. STREET ADDRESS <i>34 Lafayette Ave</i>			
3. NAME OF DECEASED (Type or print) <i>Hermon P. Johnson</i>				4. DATE OF DEATH <i>Aug. 31 1956</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Colored</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>May 1866</i>	
9. AGE (In years last birthday) <i>90</i>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Amapolis</i>	
13. FATHER'S NAME <i>Unknown</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <i>Alvin Ireland</i> Address <i>Amapolis</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>arteriosclerotic hypertensive cardiac</i> DUE TO (c) <i>vascular disease</i>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>8/30/56</i> , 1956, to <i>8/31/56</i> , 1956, that I last saw the deceased alive on <i>8/31/56</i> , 1956, and that death occurred at <i>2:00 PM</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>R. L. Richardson</i>				M.D. <i>110 - Clay St. Cleveland, Ohio</i> DATE SIGNED <i>9/1/56</i>			
PHYSICIAN'S NAME (Type) <i>R. L. RICHARDSON MD</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried Sept 3/1956</i>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <i>Brewer Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Amapolis Ind</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Annal A. Johnson</i> ADDRESS <i>Amapolis</i>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <i>Jim. C. ...</i>	
DATE <i>9/5 1956</i>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 5 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7999
CERTIFICATE OF DEATH

07869

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY A.A. County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 3 yrs. 16 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 906 N. Appleton Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Kathleen Johnson				4. DATE OF DEATH Month Day Year 8 2 19 56			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-5-03	
9. AGE (In years last birthday) 52 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charlie Brown				14. MOTHER'S MAIDEN NAME Myra Easley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) unk.		16. SOCIAL SECURITY NO. unk.		17. INFORMANT Crownsville State Hospital Crownsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left sided heart failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Due to arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Secondary hypostatic pneumonia, malnutrition, avitaminosis, decubitus 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ulcers					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. -- -- -- 19		20d. WHERE OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -- -- --		20f. (City or town) (County) (State) -- -- --	
21. I certify that I attended the deceased from July 17 , 19 53 , to August 2 , 19 56 , that I last saw the deceased alive on August 2 , 19 56 , and that death occurred at 8:35 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Maryland DATE SIGNED 8-2-56							
ACTUAL SIGNATURE <i>[Signature]</i> M.D. Crownsville, Maryland				DATE SIGNED 8-2-56			
PHYSICIAN'S NAME (Type) Ludwig Benedict, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/4/56		22c. NAME OF CEMETERY OR CREMATORY Brewer Hill Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i> ADDRESS Annapolis, Md.				24a. REC'D BY REGISTRAR DATE AUG 5 1956		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON, D.C.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7910

CERTIFICATE OF DEATH

07871

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Fort G. G. Meade</u>		LENGTH OF STAY (in this place) <u>12 years</u>		TOWN <u>Turners Station</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u>				627 New Pittsburgh Avenue			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>SUSAN RENE JONES</u>				<u>August 8 1956</u>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>Female</u>		<u>Negro</u>		<u>Single</u>		<u>4 August 1956</u>	
9. AGE last birthday		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>Yrs.</u>		<u>None</u>		<u>None</u>		<u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	
<u>USA</u>		<u>Louis Jones, Jr.</u>		<u>Mary Yvonne Henderson</u>		<u>No</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		18. MEDICAL CERTIFICATION			
<u>None</u>		<u>Mother, 627 New Pittsburgh Avenue, Balto, Md.</u>		I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <u>Premature</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Premature</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from <u>Aug 8 1956</u> to <u>Aug 8 1956</u> that I last saw the deceased alive on <u>Aug 8 1956</u> and that death occurred at <u>6:15 PM</u> from the causes and on the date stated above.			
SIGNATURE <u>Michael M. Dobridge</u> M.D. <u>12101 Bushey Dr. Wheaton, Md. Aug 8 1956</u>		DATE SIGNED		23. BURIAL, CREMATION, REMOVAL (SPECIFY)			
24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE		26. ADDRESS			
<u>W. L. Saylor</u>		<u>W. L. Saylor</u>		<u>12101 Bushey Dr. Wheaton, Md.</u>			
DATE <u>9 Aug 56</u>		1ST LT. MSC		27. ADDRESS			

7 A 1000

71 200

115

7872

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>2 A</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <u>MD</u>		b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Minneapolis</u>		c. LENGTH OF STAY IN lb <u>5 MINUTES</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shadyside</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Brundel General</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <u>Cosalie</u> Middle <u>Dunbar</u> Last <u>Keen</u>		4. DATE OF DEATH		Month <u>Aug.</u> Day <u>8</u> Year <u>1956</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 28 1909</u>	
9. AGE (In years last birthday) <u>46</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sec - Book Keeper</u>		11. BIRTHPLACE (State or foreign country) <u>Charleston S. C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Millard F. Keen Shadyside MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary artery atherosclerosis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>56</u> , to <u>August</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Aug 8</u> , 19 <u>56</u> , and that death occurred at <u>6:45</u> M., from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>90 Cathedral St. Arlington, Va.</u> DATE SIGNED <u>8/8/56</u>							
ACTUAL SIGNATURE <u>John A. Hardaway</u>		PHYSICIAN'S NAME (Type) <u>Arlington, Va.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 12/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardaway Salisbury Md.</u>				24a. REC'D BY REGISTRAR DATE <u>8/14/56</u>		24b. REGISTRAR'S SIGNATURE <u>J. D. ...</u>	

3

ESTABLISHED

1936

WILSON

CERTIFICATE OF DEATH

07873

Reg. Dist. No. 24

7911

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Anne-Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
TOWN <u>GLEN BURNIE</u>				TOWN <u>Cherry-Hill</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PLAZA MAJOR CONVALESCENCE HOME</u>				STREET ADDRESS (If rural give location) <u>429 Roundview Rd.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>BESSIE</u> (Middle) <u>K</u> (Last) <u>ESS</u>				(Month) <u>Aug</u> (Day) <u>10</u> (Year) <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widow</u>	8. DATE OF BIRTH	9. AGE last birthday <u>60</u> yrs.	IF UNDER 1 YEAR		
						Months	Days
						Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At-Home</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis Md.</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>WESLEY HAMMOND</u>				14. MOTHER'S MAIDEN NAME <u>MARY BUTLER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS <u>Joseph Monroe</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>ARTERIO SCLEROSIS,</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>GENERAL</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>CHRONIC PYELITIS</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov</u> 19 <u>55</u> , to <u>Aug 10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Aug 8</u> , 19 <u>56</u> , and that death occurred at <u>3:30 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Joseph Taler</u> M.D.				ADDRESS (Street, city, town, state) <u>Glen Burnie, Md.</u>		DATE SIGNED <u>8/10/1956</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>8-15-56</u>		NAME OF CEMETERY OR CREMATORY <u>Mt Calvary Am Brookly and</u>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR <u>8/14/56</u>		REGISTRAR'S SIGNATURE <u>L. J. De Alba</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Chas O. Wilson</u>		ADDRESS <u>5000</u>	

INSTRUCTIONS

1. PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy shall be retained by the hospital or attending physician.

2. FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

U. S. DEPARTMENT OF AGRICULTURE

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7913

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>			
CITY <u>RURAL - ANNAPOLIS</u>		CITY <u>RURAL - ANNAPOLIS</u>		CITY <u>RURAL - ANNAPOLIS</u>			
TOWN <u>ANNAPOLIS</u>		TOWN <u>ANNAPOLIS</u>		TOWN <u>ANNAPOLIS</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SAME</u>		STREET ADDRESS <u>SAME</u>		STREET ADDRESS <u>SAME</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>BERTHA MARIE Kluge</u>				<u>August 2 1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>OCTOBER 3, 1883</u>	
9. AGE last birthday <u>72</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Stettin, Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HERMAN FREDERICK Hohne</u>		14. MOTHER'S MAIDEN NAME <u>Albertina Schmidt</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS <u>Bert Kluge - Rt 4 Box 4 Annapolis</u>		18. MEDICAL CERTIFICATION		19. DATE OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)	
IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>		ANTECEDENT CAUSE(S) DUE TO (B) <u>Essential Hypertension</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (Second) M. <input type="checkbox"/> P. <input type="checkbox"/>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Arteriosclerosis, Generalized</u>		21e. INJURY OCCURRED While <input type="checkbox"/> or work Not while <input type="checkbox"/> of work		21f. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from <u>11/22, 1956</u> , to <u>8/2, 1956</u> , that I last saw the deceased alive on <u>8/2, 1956</u> , and that death occurred at <u>12:27 P.M.</u> from the causes and on the date stated above.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Aug 10, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Calver Hill Cem.</u>		LOCATION (City, town, or county) (State) <u>Maryland</u>	
24. REC'D BY REGISTRAR <u>W. G. French</u>		REGISTRAR'S SIGNATURE <u>W. G. French</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. G. French</u>		ADDRESS <u>W. G. French</u>	
DATE <u>Aug 7, 1956</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. G. French</u>		ADDRESS <u>W. G. French</u>			

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

BUREAU OF

1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in blank in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

7914 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07876										
Item 9, Film #201, MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No. 24										
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Chesington</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Pasadena</u>			c. LENGTH OF STAY IN 1b <u>5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>N. Chesington</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Seaboard Point</u>					d. STREET ADDRESS <u>6041 - 20th St.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Isaac Jackson Land</u>					4. DATE OF DEATH Month/Day/Year <u>8/16/56</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/12/95</u>		9. AGE (In years last birthday) <u>60</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile Bus</u>		11. BIRTHPLACE (State or foreign country) <u>Florida</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Charles H Land</u>					14. MOTHER'S MAIDEN NAME <u>Lucie Williams</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>57525-6336</u>		17. INFORMANT Address <u>Mesropie Land 1141</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 1430.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
SIGNATURE <u>Martha A. Parker-Dub</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>STAFF - H. ALBERT - MD</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/19/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Peninsula Memorial Park - Warwick, Va.</u>			22d. LOCATION (City, town, or county) (State) <u>Warwick, Va.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marion H. Hysong Co.</u>					ADDRESS <u>1300 - N. St. N. Washington, D.C.</u>		24. REG'D BY REGISTRAR <u>8/16/56</u>		24b. REGISTRAR'S SIGNATURE <u>L. J. Bell</u>	

MEDICAL CERTIFICATION

BUREAU A. S.

AUG 20 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7915

CERTIFICATE OF DEATH

07877 28

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 6yrs. 3mos. 15days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS 872 1/2 Pierce Street	
3. NAME OF DECEASED (Type or print) First Augusta Middle Lewisman Last Lewisman		4. DATE OF DEATH Month 8 Day 27 Year 19 56	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Not given
9. AGE (In years last birthday) 76 1/2 yrs.		IF UNDER 1 YEAR: Months — Days — Hours — Min — IF UNDER 24 HRS: Months — Days — Hours — Min —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY — —	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Not listed		14. MOTHER'S MAIDEN NAME Not listed	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk. Unk.		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Hospital Records		Address Crownsville State Hospital Crownsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure (Probable Myocardial Infarction) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 9 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/12/ , 19 50 , to 8/27 , 19 56 , that I last saw the deceased alive on 8/27 , 19 56 , and that death occurred at 8 a. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE L. Benedict		ADDRESS (Street, city or town, state) Crownsville, Md.	
DATE SIGNED 8/27/56			
PHYSICIAN'S NAME (Type) L. Benedict			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 8-28-56	
22c. NAME OF CEMETERY OR CREMATORY Univ. of Md Medical School		22d. LOCATION (City, town, or county) (State) Balti ind	
23. FUNERAL DIRECTOR'S SIGNATURE William Reese, II		ADDRESS Annapolis, Md	
24a. REC'D BY REGISTRAR 1956		24b. REGISTRAR'S SIGNATURE F. M. Joyce	

BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07878

7916

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort George G. Meade</u>		LENGTH OF STAY (In this place) <u>40 minutes</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Davidsonville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u>				STREET ADDRESS (If rural give location) <u>Central Avenue & Douns ville Road</u>			
3. NAME OF DECEASED (Type or Print) <u>RICHARD T LONG</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>August 23 19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>9 May 1899</u>	9. AGE last birthday <u>57</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Veteran</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Boat Builder</u>		11. BIRTHPLACE (State or foreign country) <u>Mervland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward J. Long</u>				14. MOTHER'S MAIDEN NAME <u>Laura Buckley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		(If Yes, give war or dates of service) <u>World War I</u>		16. SOCIAL SECURITY NO. <u>212-10-9316</u>		17. INFORMANT & ADDRESS <u>Wife, Central Avenue & Douns ville Road, Davidsonville, Md.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Acute Myocardial Infarction</u>						<u>40 minutes</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
DUE TO (B) _____							
DUE TO (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>23 Aug</u>, 19<u>56</u>, to <u>23 Aug</u>, 1956, that I last saw the deceased alive on <u>23 Aug</u>, 19<u>56</u>, and that death occurred at <u>17.0 PM</u>, from the causes and on the date stated above.							
SIGNATURE <u>HARLEY D. LINDQUIST, CAPT, MC.</u>				ADDRESS (Street, city, town, state) <u>USAH, Fort G. G. Meade, Md.</u>		DATE SIGNED <u>23 Aug 56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>27 Aug 56</u>		NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR <u>DATE 23 Aug 56</u>		REGISTRAR'S SIGNATURE <u>JERRY CARSON, CWO, USA</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>BARNARD A. FINK</u>		ADDRESS <u>Glen Burnie, Maryland</u>	



17. 11/10/50

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11/10/50

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07879

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7917

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 5yrs. 7mo. 1day Baltimore City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Della Middle Maddox Last Maddox				4. DATE OF DEATH Month 8-2- Day 19 Year 56			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-6-1898	
9. AGE (In years last birthday) 58 yrs		IF UNDER 1 YEAR Months 58 Days 58 Hours 58 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Days work		10b. KIND OF BUSINESS OR INDUSTRY Days work	
11 BIRTHPLACE (State or foreign country) Virginia				12 CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Stewart				14. MOTHER'S MAIDEN NAME Ella Young			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unk.		16. SOCIAL SECURITY NO. 213-12-5035		17 INFORMANT Hospital Records		Address Crownsville State Hospital Crownsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uraemia							
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) Hypertensive Arteriosclerotic Renal Disease							
DUE TO							
(c) Old Posterior Myocardial Infarct							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Decubitus ulcer, Epilepsy, Glaucoma.							
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour 12 PM				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f (City or town)				20g (County)		20h (State)	
21. I certify that I attended the deceased from January 1, 19 51 to August 2, 19 56 , that I last saw the deceased alive on August 2, 19 56 , and that death occurred at 12:25 PM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Crownsville, Maryland				DATE SIGNED 8-2-56			
ACTUAL SIGNATURE <i>Ludwig Benedict</i>				PHYSICIAN'S NAME (Type) Ludwig Benedict, M. D.			
22a BURIAL, CREMATION, REMOVAL (Specify)		22b DATE THEREOF 8-6-56		22c NAME OF CEMETERY OR CREMATORY St. Calvary Cemetery		22d LOCATION (City, town, or county) (State) Cedar Hill Md.	
23 FUNERAL DIRECTOR'S SIGNATURE <i>Adolphus H. H. H.</i>				ADDRESS 918 W. Hill St.		24a REG'D BY REGISTRAR 7 1956	
24b REGISTRAR'S SIGNATURE <i>E. M. Joyce</i>							

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician and completely filled in by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7918 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

07880
Reg. Dist. No. 28

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 8yrs. 11mos. 9days Baltimore City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS 558 Dolphin Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Annie Middle Middle Last Mapp		4. DATE OF DEATH Month 8 Day 19 Year 19 56	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/26/69
9. AGE (In years (last birthday) yrs 86		10. IF UNDER 1 YEAR: Months 8 Days 19 Hours 19 Min. 56	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		11b. KIND OF BUSINESS OR INDUSTRY Unknown	
11c. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Lafayette Fields		14. MOTHER'S MAIDEN NAME Lucretia Rose	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Unk.		16. SOCIAL SECURITY NO Unk.	
17. INFORMANT Hospital Records		Address Crownsville State Hosp. Crownsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Septicemia DUE TO (c) Fractured left hip, surgically corrected, ACVD PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/23 19 48 to 8/19 19 56 , that I last saw the deceased alive on 8/18 19 56 , and that death occurred at 6:45a M., from the causes and on the date stated above.			
ACTUAL SIGNATURE L. Benedict		ADDRESS (Street, city or town, state) Crownsville, Md.	
PHYSICIAN'S NAME (Type) L. Benedict		DATE SIGNED 8/20/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-22-56	
22c. NAME OF CEMETERY OR CREMATORY Arbutus Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Holland Funeral Home		24. REC'D BY REGISTRAR AUG 22	
ADDRESS 1631 Duncannon		24b. REGISTRAR'S SIGNATURE H. M. Jones	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7873

CERTIFICATE OF DEATH

07881

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Id</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis,</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Annapolis, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Baby Boy</u> Middle <u>Martin</u> Last <u>Martin</u>		4. DATE OF DEATH Month <u>August</u> Day <u>21</u> Year <u>1956</u>	
5 SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>20 August 1956</u>
9 AGE (In years lost birthday) yrs <u>3</u> Months <u>13</u>		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10b KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U</u>		13. FATHER'S NAME <u>Robert Owen Martin</u>	
14. MOTHER'S MAIDEN NAME <u>Marlyn Loraine Jones</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>J. J. David Howell</u> Address <u>1414 14th St NW</u>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>116X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Immaturity</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>August 21, 1956</u> to <u>August 21, 1956</u> , that I last saw the deceased alive on <u>August 21, 1956</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>James De Paepe</u> M.D.		PHYSICIAN'S NAME (Type) <u>James De Paepe</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>August 27, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>U.S. Navy Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis, A. A. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sylvia V. Hicks</u> ADDRESS <u>43 Northwest, Annapolis</u>		24a. REC'D BY REGISTRAR DATE <u>7/27/56</u> 24b. REGISTRAR'S SIGNATURE <u>V. D. Douch</u>	

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TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **72 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE. 18

7919 **CERTIFICATE OF DEATH**

07882

Reg. Dist. No....

~~213~~

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Anne Arundel</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Anne Arundel</u>
CITY (If outside corporate limits, write RURAL or give nearest town) OR TOWN <u>Linthicum Heights</u>	LENGTH OF STAY (in this place) <u>36 yrs</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Linthicum Heights</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>505 Greenwood Rd.</u>		STREET ADDRESS (If rural give location) <u>505 Greenwood Rd.</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Henry Bernard Mateliny</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>August 20, 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 29, 1879</u>
9. AGE last birthday <u>77</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MARDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT & ADDRESS <u>Virginia Mateliny</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>		<u>June 10, 1956</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardio - Vascular Disease</u>		<u>Feb. 1956</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan - 1937</u> to <u>Aug 20, 1956</u> , that I last saw the deceased alive on <u>Aug 20, 1956</u> , and that death occurred at <u>7:40 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Chas. L. Ball</u>		ADDRESS (Street, city, town, state) <u>M.D. Linthicum</u>	
DATE SIGNED <u>8/21/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Aug 24, 1956</u>	
NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
24. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE <u>Dr. J. M. Jeffery</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Dr. Caldwell</u>	
ADDRESS <u>Glenn Burnie, Md.</u>			

U. S. S.

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7920

CERTIFICATE OF DEATH

07883

Reg. Dist. No.

25

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Md.</u>	
c. LENGTH OF STAY IN 1b <u>67</u>		d. STREET ADDRESS <u>5726 Pope St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5726 Pope St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Catherine McCurtin</u>		4. DATE OF DEATH Month <u>August</u> Day <u>19</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 1874</u>
9. AGE (In years lost birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Henry Stimpf</u>		14. MOTHER'S MAIDEN NAME <u>Gesina</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Jeanne McCurtin</u>		Address <u>5726 Pope St.</u>	
18. CAUSE OF DEATH [Enter only one cause per-line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>fractured 1st rib</u> <u>1949</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1956</u> to <u>1956</u> that I last saw the deceased alive on <u>12-19-56</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE: <u>George J. Bond</u>		DATE SIGNED <u>August 21, 1956</u>	
PHYSICIAN'S NAME (Type) <u>George J. Bond</u>		ADDRESS <u>1101 N. ...</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug. 22, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Bond</u>		24a. REC'D BY REGISTRAR <u>116 29 1956</u>	
ADDRESS <u>1101 N. ...</u>		24b. REGISTRAR'S SIGNATURE <u>Edw. ...</u>	

RECEIVED

JUN 29 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7921

CERTIFICATE OF DEATH

Reg. Dist. No.

28

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville			c. LENGTH OF STAY IN 1b 29 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Skidmore, Maryland		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle T. Last Mealey				4. DATE OF DEATH Month 8 Day 9 Year 1956			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-24-1878		9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oystering, Waitor			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Thomas Mealey				14. MOTHER'S MAIDEN NAME Georgia Mealey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records Address _____			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Uraemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Dehydration, Malnutrition and old age DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month _____ Day _____ Year 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 7-12 , 19 56 , to 8-9-56 , 19____, that I last saw the deceased alive on 8-9-56 , 19____, and that death occurred at 2:15 p.m., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 8-9-56							
ACTUAL SIGNATURE [Signature] M.D. Crownville, Maryland				DATE SIGNED 8-9-56			
PHYSICIAN'S NAME (Type) Ludwig Benedict, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 8-12-56		22c. NAME OF CEMETERY OR CREMATORY Union Cemetery		22d. LOCATION (City, town, or county) (State) Chester Md	
23. FUNERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS _____				24a. REC'D BY REGISTRAR [Signature] DATE AUG 10 1956		24b. REGISTRAR'S SIGNATURE [Signature]	

RECEIVED
AUG 15 1956
BUCHANAN V. B.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7922

CERTIFICATE OF DEATH

07886 28

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 56 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle Edward Last Moore				4. DATE OF DEATH Month 8 Day 19 Year 56			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Not given	
9. AGE (In years last birthday) 79? yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not given		10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (State or foreign country) Not given	
12. CITIZEN OF WHAT COUNTRY? U. S.				13. FATHER'S NAME Not listed			
14. MOTHER'S MAIDEN NAME Not given				15. WAS DECEASED LISTED IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk. (If yes, give war or dates of service) Unk.			
16. SOCIAL SECURITY NO. 213-814249				17. INFORMANT Hospital Records Address Crownsville State Hosp. Crownsville, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure DUE TO Hypertensive Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 6/24 , 19 56 , to 8/19 , 19 56 , that I last saw the deceased alive on 8/19 , 19 56 , and that death occurred at 3:55 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 8/20/56 ACTUAL SIGNATURE [Signature] M.D. [Signature] PHYSICIAN'S NAME (Type) L. Benedict							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-23-56		22c. NAME OF CEMETERY OR CREMATORY Brunswick Co. Co. 2a		22d. LOCATION (City, town, or county) (State) Brunswick Co. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles Alexander Ben Theodore Song				24a. REC'D BY REGISTRAR DATE Aug. 21, 1956		24b. REGISTRAR'S SIGNATURE H. M. Joyce	

11/11/56 K 15

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7923

CERTIFICATE OF DEATH

07887

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>H. George G. Meade</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u> <u>Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Army Hospital</u>		d. STREET ADDRESS <u>Threestes Trailer Court</u>	
3. NAME OF DECEASED (Type or print) <u>Kathryn L Moore</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>19</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>31 MAY 1907</u>
9. AGE (In years, last birthday) <u>48</u> yrs		10. IF UNDER 1 YEAR: IF UNDER 24 HRS: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTH PLACE (State or foreign country) <u>STATESVILLE, N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN A. RUMPLE</u>		14. MOTHER'S MAIDEN NAME <u>DORA TROUTMAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>45-3-22-65</u>	
17. INFORMANT <u>(Husband) Robert F. Moore</u>		Address <u>THREESTES TRAILER COURT, SEVERN, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u> DUE TO <u>with cerebrovascular accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic nephritis</u> DUE TO (c) <u>Chronic nephritis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anemia, Status post abd + femoral operation</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>19 Aug., 1956</u> , to <u>19 Aug., 1956</u> , that I last saw the deceased alive on <u>19 Aug., 1956</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>U.S. Army Hospital Ft. S.G. Meade</u> <u>20 Aug 56</u>	
PHYSICIAN'S NAME (Type) <u>Robert S. Pokusoh, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>20 Aug 56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>TROUTMAN CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>STATESVILLE, N.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN J. COWAN</u>		ADDRESS <u>901 HOLLINS ST. BALTIMORE, MD.</u> 24a. REC'D BY REGISTRAR <u>[Signature]</u> 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 28 1944

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 1 day	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		d. STREET ADDRESS 46 Lafayette	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Girl		4. DATE OF DEATH Morrow August 12 19 56	
5 SEX Female	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 August 1956
9 AGE (In years last birthday) 1		IF UNDER 1 YEAR 1 IF UNDER 24 HRS. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Lonnie Joseph Morrow		14. MOTHER'S MAIDEN NAME Phelia Mary Butler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT U. S. Naval Hospital Records		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH one day	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis			
7/12/56 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Prematurity with immaturity	
		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-11, 1956 to 8-12, 1956 , that I last saw the deceased alive on 8-12, 1956 , and that death occurred at 6:45P M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED 11-9-56	
ACTUAL SIGNATURE Francesco De Paola, Lt., MC, USNR		M.D. U. S. Naval Hospital, Annapolis, Md. 8/13/56	
PHYSICIAN'S NAME (Type) FOR: S. R. FETERS, LCD, MC, USN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-15-56	22c. NAME OF CEMETERY OR CREMATORY U. S. Naval Academy	22d. LOCATION (City, town, or county) (State) Annapolis Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Reese II ADDRESS Annapolis, Md.		24a. RECEIVED BY REGISTRAR Mr. J. L. Lundy 24b. REGISTRAR'S SIGNATURE Mr. J. L. Lundy	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2051191XVI

BUREAU V. S.

NOV 10 1907

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7874 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07888

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>L. I. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lees Burnie</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Lees General Hosp.</u>				d. STREET ADDRESS <u>6011 Elbridge Rd</u>			
3. NAME OF DECEASED (Type or print) First <u>VIRGIE M.</u> Middle <u>Eden</u> Last <u>Eden</u>				4. DATE OF DEATH Month <u>8</u> Day <u>6</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-1-11</u>	
9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>			
11. BIRTHPLACE (State or foreign country) <u>Lees Burnie, Md</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Robert H. Hall</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Leither</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>7-2-55-214</u>			
17. INFORMANT <u>William Eden - Lees Burnie Md</u>				Address <u>Lees Burnie Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Disease</u> <u>4343</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>0</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
EXAMINER'S SIGNATURE <u>E. Linhardt</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. Linhardt</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>8/6/56</u>			
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-6-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lees Burnie</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. French</u>				ADDRESS <u>Lees Burnie Md</u>			
24a. REC'D BY REGISTRAR <u>Aug 7, 1956</u>				24b. REGISTRAR'S SIGNATURE <u>Wm. J. French</u>			

RECEIVED
AUG 10 1950
BUREAU OF

10829 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 0993628

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		e. STREET ADDRESS 1641 Westwood Avenue	
3. NAME OF DECEASED (Type or print) First WESLEY Middle PEOPLES Last		4. DATE OF DEATH Month August Day 27 Year 1956	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 74 yrs.
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Eric Peoples		14. MOTHER'S MAIDEN NAME Mathilde Richardson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis DUE TO (b) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE William V. Lovitt, Jr.		DATE SIGNED 11/2/56	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 10-16-56	22c. NAME OF CEMETERY OR CREMATORY Anatomy Board	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REG'D BY REGISTRAR DATE Nov. 7, 1956	24b. REGISTRAR'S SIGNATURE H. M. Joyce

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 8

1956

RECEIVED

7875

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>53 W. Washington St</u>		d. STREET ADDRESS <u>53 W. Washington St</u>	
3. NAME OF DECEASED (Type or print) <u>Robert Perry</u>		4. DATE OF DEATH Month <u>8</u> Day <u>5</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-15-1864</u>
9. AGE (In years last birthday) <u>92</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Naval Academy, N.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Perry</u>		14. MOTHER'S MARDEN NAME <u>Elizabeth Skinner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u> </u>	
17. INFORMANT <u>Dena Swain</u>		Address <u>7329 Sycamore Ave. P. Mott</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Arterio-sclerotic Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Cardiovascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u> </u> Hour a. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7/26</u> , 19 <u>56</u> , to <u>8/5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8/5</u> , 19 <u>56</u> , and that death occurred on <u>8/5</u> , 19 <u>56</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Rob. Richardson</u>		ADDRESS (Street, city or town, state) <u>110 Bay & Annapolis Ind.</u>	
PHYSICIAN'S NAME (Type) <u> </u>		DATE SIGNED <u>8/7/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-8-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bruce Hill</u>	22d. LOCATION (City, town or county) (State) <u>Annapolis Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William R. H. - Annapolis, Md</u>		24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 16 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07890 28

DUPLICATE

7924

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 8 mos. 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Pervines Last Pervines		4. DATE OF DEATH Month 8 Day 12 Year 1956	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH unk.
9. AGE (In years last birthday) 77? yrs		10. IF UNDER 1 YEAR Months 7 Days 7 Hours 7 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unemployed		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unk.		14. MOTHER'S MAIDEN NAME Unk.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Records		Address Crownsville State Hospital Crownsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic debilitated patient DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. Month 12 Day 17 Year 1955 p. m. 12		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-17 , 19 55 , to 8-12 , 19 56 , that I last saw the deceased alive on 8-12-56 , and that death occurred at 3:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Ludwig Benedict		ADDRESS (Street, city or town, state) Crownsville, Maryland	
PHYSICIAN'S NAME (Type) Ludwig Benedict, M. D.		DATE SIGNED 8-12-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 9-2-56		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Asbury		22d. LOCATION (City, town, or county) (State) Annapolis, Md	
23. FUNERAL DIRECTOR'S SIGNATURE William F. Lee		24a. PREPARED BY REGISTRAR SEP 1 1956	
ADDRESS Annapolis, Md		24b. REGISTRAR'S SIGNATURE L. M. J. J.	

RECEIVED

SEP 7 1950

BUREAU V. S.

1 HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07891

7925

CERTIFICATE OF DEATH

Reg. Dist. No.

28

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 118 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Pettiford Last Pettiford		4. DATE OF DEATH Month 8 Day 24 Year 19 56	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/18/20
9. AGE (In years last birthday) yrs 35		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Not given		14. MOTHER'S MAIDEN NAME Bera Pettiford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk. Unk.		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Hospital Records		Address Crownsville State Hospital Crownsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) Malnutrition and Dehydration DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Occlusive Vascular Disease, Anemia, Acute & Chronic Brain Syndrome			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 0 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/8 , 19 56 to 8/24 , 19 56 , that I lost saw the deceased alive on 8/23 , 19 56 , and that death occurred at 5:50a M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Lionel McHenry Mapp M.D.		ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 8/24/56	
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/27/56	
22c. NAME OF CEMETERY OR CREMATORY Yorkboro Cem.		22d. LOCATION (City, town, or county) (State) Yorkboro Va	
23. FUNERAL DIRECTOR'S SIGNATURE L. C. ...		24a. REC'D BY REGISTRAR Aug 30	
ADDRESS ...		24b. REGISTRAR'S SIGNATURE H. M. Jones	

RECEIVED

AUG 30 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07892

Reg. Dist. No. 21

7876

1. PLACE OF DEATH a. COUNTY <u>JANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>MD</u> c. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>1 DAY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Richmond</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPARROWS BEACH</u>				d. STREET ADDRESS <u>512 E. FEDERAL ST.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FLOYD THOMAS PULLER</u>				4. DATE OF DEATH Month Day Year <u>August 13 1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 2 1918</u>	9. AGE (in years last birthday) <u>37</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAS. H. PULLER</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH HARRIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>22K173981</u>		17. INFORMANT Address <u>JAS. ALLEN - Richmond VA.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> <u>929.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>929.8</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>SPARROWS BEACH</u>		20f. (City or town) (County) (State) <u>AA.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R. Fisher</u> M.D.				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/16/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodland</u>		22d. LOCATION (City, town, or county) (State) <u>Richmond VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Wm. I. CHATMAN, JR. 1701 McCulloch</u>				24a. REC'D BY REGISTRAR <u>AUG 15 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. J. French</u>	

MEDICAL CERTIFICATION

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the State Department of Health, Office of Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1956

1956

1956

7926

CERTIFICATE OF DEATH

Reg. Dist. No.

28

1. PLACE OF DEATH a. COUNTY Crownsville, MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City				
c. LENGTH OF STAY IN 1b 1 mo. 26 days				d. STREET ADDRESS 1500 McCulloh Street				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Andrew			First			Middle		
Queen			Last			4. DATE OF DEATH Month 8 Day 17 Year 19 56		
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 6, 1883 ?		
9. AGE (In years lost birthday) 73 ? yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Caterer				10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Unknown		
12. CITIZEN OF WHAT COUNTRY? U.S.A.								
13. FATHER'S NAME James Queen				14. MOTHER'S MAIDEN NAME Susie Queen				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unk.		16. SOCIAL SECURITY NO. unk.		17. INFORMANT Hospital Records				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary Tb. DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)								
21. I certify that I attended the deceased from June 22 , 19 56 , to Aug. 17 , 19 56 , that I last saw the deceased alive on Aug. 17 , 19 56 , and that death occurred at 6:20 a.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Maryland DATE SIGNED 8-17-56								
ACTUAL SIGNATURE <i>[Signature]</i> M.D. Crownsville, Maryland				8-17-56				
PHYSICIAN'S NAME (Type) Ludwig Benedict, M. D.								
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Aug. 21, 1956		22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn		22d. LOCATION (City, town, or county) (State) Baltimore Md.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i> ADDRESS 1631				24a. REC'D BY REGISTRAR 21.1956		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
AUG 21
BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 22 FilmG203 9-14-56 et

07894

CERTIFICATE OF DEATH

7928

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Holland Point, Anne Arundel</u> <u>MD</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Chesapeake Beach</u>				STATE <u>Virginia</u> COUNTY <u>Arlington</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>1008 North Quincy St. Arlington Va.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Indem Joseph Redding</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>August 25, 19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>August 19 1900</u>	9. AGE last birthday <u>56</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Buckingham Apts.</u>		11. BIRTHPLACE (State or foreign country) <u>Lecanta Florida</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James Redding</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Hurst</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>264-05-7617</u>		17. INFORMANT & ADDRESS <u>1008 North Quincy St. Arlington Va.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Asphyxiation</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of injury street, office bldg. etc.) <u>Chesapeake Bay</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>near Beach</u> <u>A.A.W. Md.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>August 18 1956 P.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fell from row boat.</u>			
22. I hereby certify that I attended the deceased from <u>until death</u> to <u>Aug 18, 1956</u> , that I last saw the deceased alive on <u>inter alia</u> , 19 <u>10 P.M.</u> , and that death occurred at <u>from the causes and on the date stated above.</u>							
SIGNATURE <u>Enrich H. Wilson, acting coroner</u> M.D.				ADDRESS (Street, city, town, state) <u>1008 North Quincy St. Arlington Va.</u>		DATE SIGNED <u>8/29/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9-4-56</u>		NAME OF CEMETERY OR CREMATORY <u>Columbia Gardens</u>		LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
24. REC'D BY REGISTRAR <u>8/30/56</u>		REGISTRAR'S SIGNATURE <u>J. V. D. D. D.</u>		FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty</u>		ADDRESS <u>Belvidere</u>	

BUREAU V. S.

3 - 10 - 1966

W. S. 129, 128, 127, 126, 125, 124, 123, 122, 121, 120, 119, 118, 117, 116, 115, 114, 113, 112, 111, 110, 109, 108, 107, 106, 105, 104, 103, 102, 101, 100, 99, 98, 97, 96, 95, 94, 93, 92, 91, 90, 89, 88, 87, 86, 85, 84, 83, 82, 81, 80, 79, 78, 77, 76, 75, 74, 73, 72, 71, 70, 69, 68, 67, 66, 65, 64, 63, 62, 61, 60, 59, 58, 57, 56, 55, 54, 53, 52, 51, 50, 49, 48, 47, 46, 45, 44, 43, 42, 41, 40, 39, 38, 37, 36, 35, 34, 33, 32, 31, 30, 29, 28, 27, 26, 25, 24, 23, 22, 21, 20, 19, 18, 17, 16, 15, 14, 13, 12, 11, 10, 9, 8, 7, 6, 5, 4, 3, 2, 1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to "final" cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7927

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07895

Reg. Dist. No.

24

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Same b. COUNTY Same			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena				c. LENGTH OF STAY IN lb 2 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Old Annapolis Rd.				d. STREET ADDRESS Same		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Frederick Last Reinhardt				4. DATE OF DEATH Month August Day 28th Year 19 56			
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 2/16/96	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months 60 Days 0 Hours 0 Min.	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired bar tender.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis F. Reinhardt				14. MOTHER'S MAIDEN NAME Emma Harrison			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) War 1 Army		16. SOCIAL SECURITY NO. 212-18-7333		17. INFORMANT Mrs. Alonzo Reinhardt (Brother). Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sudden DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Gustave H. Faubert</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		8/28/56		DATE SIGNED	
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 31, 1956		22c. NAME OF CEMETERY OR CREMATORY Balto. Nat. Cem.		22d. LOCATION (City, town, or county) (State) 5501 Fredk. Ave.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>George Jones</i>		ADDRESS 400I Ritchie Hwy.		24a. REC'D BY REGISTRAR SEP 4 1956		24b. REGISTRAR'S SIGNATURE <i>L. J. DeLia</i>	

U.S. AIR FORCE

1956

100

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07896

CERTIFICATE OF DEATH

Reg. Dist. No.

28

7929

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 8mos.22 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS 211 Reliance Avenue	
3. NAME OF DECEASED (Type or print) First George Middle Henry Last Roach		4. DATE OF DEATH Month 8 Day 25 Year 19 56	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 1, 1885
9. AGE (In years last birthday) yrs. 71		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown Day Laborer Concrete Plant	
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Unknown Henry Roach		14. MOTHER'S MAIDEN NAME Unknown Mary Ann Masten	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Unknown No		16. SOCIAL SECURITY NO. 216-12-7740	
17. INFORMANT Hospital Records		Address Crownsville State Hospital Crownsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Arteriosclerotic Cardiovascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12/3 , 19 55 , to 8/25 , 19 56 , that I last saw the deceased alive on 8/25 , 19 56 , and that death occurred at 8:20 p. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 8/25/56			
ACTUAL SIGNATURE L. Benedict M.D.		PHYSICIAN'S NAME (Type) L. Benedict	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 8/29/56	22c. NAME OF CEMETERY OR CREMATORY Federal Hill Cemetery	22d. LOCATION (City, town, or county) (State) Federalburg Md.
23. FUNERAL DIRECTOR'S SIGNATURE L. J. Frampton Sen		24a. REC'D BY REGISTRAR DATE Aug 30	24b. REGISTRAR'S SIGNATURE

8 A 09JNDH

1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and no any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07897

7877

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. GENERAL HOSPT</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> d. STREET ADDRESS <u>81 WEST ST</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WILBUR</u> Middle <u>I</u> Last <u>ROBERTS</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>14</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-3-1915</u>
9. AGE (In years last birthday) <u>40</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK DRIVER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BEER</u>	
11. BIRTHPLACE (State or foreign country) <u>ANNAPOLIS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William S. Roberts</u>		14. MOTHER'S MAIDEN NAME <u>Alberta Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year of service)		16. SOCIAL SECURITY NO <u>No</u>	
17. INFORMANT <u>Willbur E. Roberts - Hyannis Mass.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u> DUE TO <u>Cirrhosis of Liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Esophageal Varices</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>15 hrs</u> <u>1 wk</u> <u>1 wk</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Alcoholism Chronic</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-14-1956</u> to <u>8-14-1956</u> , that I last saw the deceased alive on <u>8-14-1956</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James E. Martin</u>		DATE SIGNED <u>8/16/56</u>	
PHYSICIAN'S NAME (Type) <u>JAMES E. MARTIN</u>		M.D. <u>Annapolis, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Aug 17-56</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Son</u>		24. REC'D BY REGISTRAR <u>MD</u>	
ADDRESS <u>Annapolis MD</u>		24a. REGISTRAR'S SIGNATURE <u>U. Williams</u>	
DATE <u>8/17/56</u>			

RECEIVED

11 20 1956

7930

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Fort George G. Meade</u>		LENGTH OF STAY (in this place) <u>3 1/2 Years</u>		TOWN <u>Dundalk</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u>				Route #3, Box 246			
3. NAME OF DECEASED (Type or Print) <u>CHRISTOPHER</u> (First) <u>ROSS</u> (Last)				4. DATE OF DEATH (Month) <u>August</u> (Day) <u>22</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH <u>August 22, 1956</u>	
9. AGE last birthday <u>4</u> yrs.		10. IF UNDER 1 YEAR (Months) <u>4</u> (Days) <u>19</u> (Hours) <u>56</u> (Min.)		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if not []) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Frank Eldred Ross, Jr.</u>				14. MOTHER'S MAIDEN NAME <u>Violet Grace Holton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Father, 1 Baylor Road, Glen Burnie, Maryland</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Atelectasis</u> <u>Atelectasis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Prematurity</u> <u>Prematurity</u>				4 hours			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Placenta Previa</u> <u>Placenta Previa</u>				4 Hours			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>22 Aug 56</u> to <u>22 Aug 56</u>, that I last saw the deceased alive on <u>22 Aug 56</u>, and that death occurred at <u>5:00 PM</u>, from the causes and on the date stated above.							
SIGNATURE <u>James A. Singleton, M.D.</u>				ADDRESS (Street, city, town, state) <u>USAH Ft Det & Med Md 22 Aug</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>23 Aug 56</u>		NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Towson, Maryland</u>	
24. REC'D BY REGISTRAR <u>William J. Saylor</u>		REGISTRAR'S SIGNATURE <u>W.L. Saylor, 1ST LT, USA</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>WM. Cook Inc.</u>		ADDRESS <u>Baltimore, Maryland</u>	
DATE <u>22 Aug 1956</u>		DATE <u>22 Aug 1956</u>		DATE <u>22 Aug 1956</u>		DATE <u>22 Aug 1956</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

U. S. DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

7878

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. GENERAL Hospt.</u>		d. STREET ADDRESS <u>719 WARREN DRIVE</u>	
3. NAME OF DECEASED (Type or print) <u>ALLAN</u> First <u>THOMAS</u> Middle <u>SATCHELL</u> Last		4. DATE OF DEATH <u>August 20</u> Month <u>1954</u> Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/16/56</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES E. SATCHELL</u>		14. MOTHER'S MAIDEN NAME <u>GRETCHEN I. MYERS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>CHARLES E. SATCHELL</u> Address <u>#2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adipose tissue infarct - old thrombosis</u> <u>154.4</u> DUE TO <u>thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>16</u> city, 19 <u>54</u> , to <u>20</u> city, 19 <u>54</u> , that I last saw the deceased alive on <u>19</u> city, 19 <u>54</u> , and that death occurred at <u>3:12</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1111 1st St. N.E. Washington, D.C.</u> DATE SIGNED <u>20 Aug 1954</u>			
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>[Signature]</u>			
PHYSICIAN'S NAME (Type) <u>John M. Taylor & Sons</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>8/22/54</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Easton Mo.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u> ADDRESS <u>Annapolis, MD</u>		24. REC'D BY REGISTRAR <u>[Signature]</u> 25. REGISTRAR'S SIGNATURE <u>[Signature]</u> DATE <u>23 1954</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 24 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 6202

7931

CERTIFICATE OF DEATH

07900

Reg. Dist. No.

28

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 6 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
				d. STREET ADDRESS 723 Malvin Avenue			
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First Middle Last Jessie Saunders				Month Day Year 8 19 56			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-18-1901	9. AGE (In years, last birthday) yrs 55	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not known				10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME Samuel Taylor				14. MOTHER'S MAIDEN NAME Elizabeth Parker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Hospital Records			
				Address Crownsville State Hospital Crownsville, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure L.U.I. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Possible myocardial infarction DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary edema							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 8/13 , 19 56 to 8/19 , 19 56 , that I last saw the deceased alive on August 19 , 19 56 , and that death occurred at 12 midnight , from the causes and on the date stated above.							
ACTUAL SIGNATURE L. Benedict				ADDRESS (Street, city or town, state) Crownsville, Md.			
PHYSICIAN'S NAME (Type) L. Benedict				DATE SIGNED 8/20/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 8-23-56		22c. NAME OF CEMETERY OR CREMATORY Fowlers Chapel		22d. LOCATION (City, town, or county) (State) Best Gate Md	
23. FUNERAL DIRECTOR'S SIGNATURE William Reese - Annapolis Md.				24a. REC'D BY REGISTRAR DATE 8 22 1956		24b. REGISTRAR'S SIGNATURE H. M. Jones	

BUREAU V. S.

1906

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07901

CERTIFICATE OF DEATH

Reg. Dist. No. 24

7932

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		MARYLAND		STATE MARYLAND		COUNTY Glen Burnie	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN				TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 421 Ritchie Highway				STREET ADDRESS (If rural give location) 421 Ritchie Highway			
3. NAME OF DECEASED (Type or Print) Sarah Lavnia Schmeiser				4. DATE OF DEATH 8 / 1 / 1956			
5. SEX Female		6. CO. OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed		8. DATE OF BIRTH January 1, 1879	
				9. AGE last birthday 77 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Seamstress				10b. KIND OF BUSINESS OR INDUSTRY L. Greenbaum Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME ? Collison				14. MOTHER'S MAIDEN NAME ? Haycock			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No				16. SOCIAL SECURITY NO. ?			
17. INFORMANT & ADDRESS Mr. Vernon Schmeiser-528 Meadoway Park				Worthington, Ohio			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				10 mas			
IMMEDIATE CAUSE (A) Carcinoma breast & Metastases							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)			
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)				21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
21f. HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from May 1956, to August 1956, that I last saw the deceased alive on 7-31 1956, and that death occurred at 11:30 PM, from the causes and on the date stated above.							
SIGNATURE O. B. MacDonnell M.D.				DATE SIGNED 8-1-56			
ADDRESS (Street, city, town, state)							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				DATE THEREOF 8/6/56			
NAME OF CEMETERY OR CREMATORY Western Cemetery				LOCATION (City, town, or county) Baltimore, Maryland			
24. REC'D BY REGISTRAR L. J. Adell				25. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Jackson - North Pa			
DATE AUG 6 1956				ADDRESS Baltimore, Md.			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

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TELETYPE

7933

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Weems Creek		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Weems Creek	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 339 Rt 4 Annapolis		d. STREET ADDRESS Box 339 Rt 4 Annapolis	
3. NAME OF DECEASED (Type or print) First JOHN Middle P Last SCHMICK		4. DATE OF DEATH Month AUGUST Day 26 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 20, 1879
9. AGE (In years lost birthday) 77 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 11 Days 23 Hours 19 Min 56	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor		10b. KIND OF BUSINESS OR INDUSTRY Body & Fender Shop	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Philip Schmick		14. MOTHER'S MAIDEN NAME Emma Goldsbough	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ?		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Mrs Annie G. Schmick- Wife - Same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIO-SCLEROSIS, GENERALIZED DUE TO (c) VARICELLA PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 75 HRS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/21/56 , 1956, to 8/23 , 1956, that I last saw the deceased alive on 8/23 , 1956, and that death occurred at 6:00 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Edward S. Beck		ADDRESS (Street, city or town, state) Southgate Ave. Annapolis, Maryland	
PHYSICIAN'S NAME (Type) Edward S. Beck MD		DATE SIGNED 8/24/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 27, 1956	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Anne Arundel County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME		ADDRESS Annapolis, Md.	
24a. REC'D BY REGISTRAR 8-25-56		24b. REGISTRAR'S SIGNATURE V. D. Douch	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 29 1956

BUREAU T. E.

CERTIFICATE OF DEATH

Reg. Dist. No.

25

7934

1. PLACE OF DEATH a. COUNTY Ann Arundel Co.				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE 107 3rd. Ave. Brooklyn Pk. Ann Arundel Co. b. COUNTY Brooklyn Park c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Park			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Park				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 107 3rd. Ave. W. Brooklyn Park			
3. NAME OF DECEASED (Type or print) M. Gertrude Schramm				4. DATE OF DEATH Month Aug. Day 16 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan/13, 1976	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY Baltimore Md.		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME Charles Wagner			
14. MOTHER'S MAIDEN NAME Unknown				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT John F. Schramm 107 3rd. Ave. Brooklyn Park Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 120.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) coronary thrombosis (c) myocardial infarction				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from May , 1952, to Aug. 14 , 1956, that I last saw the deceased alive on Aug. 14, 1956 , and that death occurred at 12:08 A.M. , from the causes and on the date stated above ADDRESS (Street, city or town, state) 3904 S. HANOVER ST. BALTIMORE MD. DATE SIGNED Aug. 16, 1956							
ACTUAL SIGNATURE Eugene Schnitzer				PHYSICIAN'S NAME (Type) Eugene Schnitzer			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 18, 1956		22c. NAME OF CEMETERY OR CREMATORY Louisa Park Cem.		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Philip Herwig Sons				24a. REC'D BY REGISTRAR Aug. 17, 1956		24b. REGISTRAR'S SIGNATURE Ida Whitson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and any event within 72 hours after death.

RECEIVED

AUG 27 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7879

CERTIFICATE OF DEATH

07904

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Ad</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Ad</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>U.S. General</u>		d. STREET ADDRESS <u>712 Neems Creek Drive</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Wilbur</u> Middle <u>T.</u> Last <u>Shawn</u>		4. DATE OF DEATH Month <u>8</u> Day <u>23</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-1-1890</u>
9. AGE (In years lost birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>	
11. BIRTHPLACE (State or foreign country) <u>Casper, Wyo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Perkins G. Shawn</u>		14. MOTHER'S MAIDEN NAME <u>Larrah G. Hoppicker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give year or dates of service) <u> </u>		16. SOCIAL SECURITY NO <u> </u>	
17. INFORMANT <u>Naomi E. Shawn</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of Brain</u> DUE TO <u>Carcinoma of lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>3 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 10, 1956</u> to <u>Aug 23, 1956</u> that I last saw the deceased alive on <u>Aug. 23, 1956</u> , and that death occurred at <u>11:50 AM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Annapolis, Md.</u> DATE SIGNED <u>8/24/56</u>	
ACTUAL SIGNATURE <u>James R. Martin</u> M.D.			
NAME (Type) <u>JAMES R. MARTIN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-26-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Knuff</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Taylor, Sr.</u>		24a. REC'D BY REGISTRAR DATE <u>8/27/56</u>	
ADDRESS <u>Annapolis Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. J. French</u>	

BUREAU Y. L.

JUG 29 1956

RECEIVED

7880

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		MARYLAND		STATE Maryland		COUNTY Anne Arundel	
CITY OR TOWN Annapolis		LENGTH OF STAY (In this place) 50 Yrs.		CITY OR TOWN Annapolis			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 120 South Street				STREET ADDRESS (If rural give location) 120 South Street			
3. NAME OF DECEASED (Type or Print) (First) BESSIE (Middle) AGNES (Last) SIMPKINS				4. DATE OF DEATH (Month) August 9, 1956 (Day) 19 (Year)			
5. SEX Female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH May 10, 1893	9. AGE last birthday 63 yrs	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? ***	
13. FATHER'S NAME Thomas Conner				14. MOTHER'S MAIDEN NAME Katie Parks			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Susie Stevens-120 South St. Annapolis			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) Congestive Heart Failure				INTERVAL BETWEEN ONSET AND DEATH Start			
ANTECEDENT CAUSE(S) DUE TO				10 days			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 8-15-56, 1956, to 8-9-56, 1956, that I last saw the deceased alive on 8-8-56, 1956, and that death occurred at 11:00 A.M. from the causes and on the date stated above.							
SIGNATURE [Signature]				ADDRESS (Street, city, town, state) DATE SIGNED 8-11-56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 8/12/1956		NAME OF CEMETERY OR CREMATORY Brewer Hill Cemetery		LOCATION (City, town, or county) (State) West St. Annapolis, Md.	
24. REC'D BY REGISTRAR DATE 8/10/56		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ethel L. Hicks-45 Northwest St. Annapolis			

1 M I INSTRUCTIONS TO ATTENDING PHYSICIAN ☐ HOSPITAL ☐ The bottom copy may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly must be detached for use as a burial transit permit.

VS AISC 1-55 10M

RECEIVED

AUG 14 1956

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Annapolis RFD</u>				TOWN <u>Glen Burnie</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cape St. Claire</u>				STREET ADDRESS (If rural give location) <u>200 Chain Hwy, S.W.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Thomas W. SINGLETON</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>August 30 1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 2, 1891</u>	9. AGE last birthday <u>65</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired) <u>Funeral Director</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>		11. BIRTHPLACE (State or foreign country) <u>Havre de Grace, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Marrian Singleton</u>				14. MOTHER'S MAIDEN NAME <u>Sarah E. Glass</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-22-9332</u>		17. INFORMANT & ADDRESS <u>Richard V. Singleton - Glen Burnie Md.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1 IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accidents</u>				6 weeks			
2 ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>							
3 DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>August 29, 1956</u> , to <u>August 30, 1956</u> , that I last saw the deceased alive on <u>August 29, 1956</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Bobby L. Jones</u>		M.D. <u>Glen Burnie Md</u>		DATE SIGNED <u>8/31/56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Sept. 3, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Angel Hill Cem.</u>		LOCATION (City, town, of county) <u>Havre de Grace, Md.</u>	
24. REC'D BY REGISTRAR <u>9/4/56</u>		REGISTRAR'S SIGNATURE <u>Wm. J. French</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Richard V. Singleton</u>		ADDRESS <u>1111 E. Belvedere Ave. Baltimore</u>	

INSTRUCTIONS:

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. After this time the bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time the death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

PROBATION V. 2

SEP 5 1966

RECEIVED
FBI - NEW YORK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 film 0201 8-20-56 et

CERTIFICATE OF DEATH

07907

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A. Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>St. 2</u>		e. STREET ADDRESS <u>St. 2</u>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Frankie Mae Smith</u>		4. DATE OF DEATH <u>8</u> <u>6</u> <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Art</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-12-1919</u>
9. AGE (In years last birthday) <u>37</u> yrs.		10. IF UNDER 1 YEAR: Months <u>3</u> Days <u>12</u> Hours <u>56</u> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Edgefield S.C.</u>	
13. FATHER'S NAME <u>Andrew Williams</u>		14. MOTHER'S MAIDEN NAME <u>Lela Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>256-18-7243</u>	
17. INFORMANT <u>Margaret Shepherd, St. 2 Arnold</u>		Address <u>St. 2 Arnold</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Metastatic Carcinoma</u> DUE TO <u>Carcinoma of uterus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-9-55</u> , 19 <u>55</u> , to <u>8-6-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8-6-56</u> , 19 <u>56</u> , and that death occurred at <u>10 P.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>ART. Allen</u>		ADDRESS (Street, city or town, state) <u>62 Cathedral St.</u>	
PHYSICIAN'S NAME (Type) <u>ARIS T. ALLEN</u>		DATE SIGNED <u>8-8-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-12-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hazel Grove</u>		22d. LOCATION (City, town, or county) (State) <u>Beech Island S.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr.</u>		ADDRESS <u>Charlottesville</u>	
24a. REC'D BY REGISTRAR <u>8/15/56</u>		24b. REGISTRAR'S SIGNATURE <u>W. Reese</u>	

BUREAU Y. E.

AUG 16 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07908

7937

CERTIFICATE OF DEATH

Reg. Dist. No. 72

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Md</u>		COUNTY <u>Ches.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Jessup</u>		LENGTH OF STAY (In this place) <u>45 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Jessup</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INST. TOWN OR STREET ADDRESS							
3. NAME OF DECEASED (Type or Print) <u>Muntle B. Stallings</u>				4. DATE OF DEATH (Month) <u>August</u> (Day) <u>7</u> (Year) <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 3 1869</u>	9. AGE last birthday <u>87</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>		11. BIRTHPLACE (State or foreign country) <u>Land Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Andrew J. Disney</u>				14. MOTHER'S MAIDEN NAME <u>Sarieth Redmiller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT & ADDRESS <u>Richard R. Anderson Jessup Md</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
22.1 IMMEDIATE CAUSE (A) <u>Arterio-sclerosis - Generalized</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chr. Myocarditis</u>				<u>3 wks.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Senility</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 1, 1956</u> to <u>Aug 7, 1956</u> , that I last saw the deceased alive on <u>8/7/56</u> , and that death occurred at <u>4:15</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Frank R. Shipley, M.D.</u>				ADDRESS (Street, city, town, state) <u>Savage, Md.</u> DATE SIGNED <u>8/12/56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)	
<u>Burial</u>	<u>Aug 9, 1956</u>	<u>Madewood Cemetery</u>		<u>Chesapeake</u>		<u>Md</u>	
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS			
<u>Aug 13 1956</u>	<u>Clara Haslop</u>	<u>Frederick R. Braddock</u>		<u>Jessup Md</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

CERTIFICATE OF DEATH

07909

Buried in 26

Reg. Dist. No. 261-

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville			c. LENGTH OF STAY IN 1b 32 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marion Station		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lida Middle STOKELY Last STOKELY		4. DATE OF DEATH Month 8 Day 18 Year 19 56					
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Not given	9. AGE (In years last birthday) 80 1/2 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Not given			14. MOTHER'S MAIDEN NAME Hennie Bondabal				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 7/17 , 19 56 , to 8/18 , 19 56 , that I last saw the deceased alive on 8/18 , 19 56 , and that death occurred at 9:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Maryland DATE SIGNED 8/18/56 ACTUAL SIGNATURE L. Benedict M.D. PHYSICIAN'S NAME (Type) L. Benedict							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug 22, 1956	22c. NAME OF CEMETERY OR CREMATORY Ward's Memorial	22d. LOCATION (City, town, or county) (State) Marion Sta. Som. Co. Md.				
23. FUNERAL DIRECTOR'S SIGNATURE Norma J. Hard-Marrow Sta., Md.			24a. REC'D BY REGISTRAR DATE 8-21-56	24b. REGISTRAR'S SIGNATURE Hattie D. Payne			

U.S. BUREAU

AUG 24 1917

RECEIVED

7939 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH a. COUNTY <u>PASADENA</u> <u>CLEAR VIEW VILLAGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena RFD - Old Brookfield</u> d. STREET ADDRESS <u>RT-8 - Box 95</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena RFD</u>	c. LENGTH OF STAY IN 1b <u>9 yrs.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HARRY</u> First <u>HALLET</u> Middle <u>STURN</u> Last		4. DATE OF DEATH Month <u>8</u> Day <u>19</u> Year <u>1956</u>	
5 SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 12, 1903</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chiropractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-Employed</u>	9. AGE (In years last birthday) <u>53</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war and dates of service) <u>1st W.W.</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT <u>George Giorgio</u> Address <u>RT-8 Box 95 Pasadena RFD</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BARBITURATE POISONING</u> <u>70.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>AND ACUTE ALCOHOLISM</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B) <u>Ingested OVERDOSE OF BARBITURATES</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>8-18</u> 19 <u>56</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>HOME</u>	20f. (City or town) <u>PASADENA</u> (County) <u>A.A.</u> (State) <u>MD</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>R. S. Fisher</u>		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>R. S. FISHER</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-24-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Balto. Nat'l</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. J. Sedha</u>		22d. LOCATION (City, town, or county) <u>Balto.</u>	(State) <u>MD</u>
24a. REC'D BY REGISTRAR <u>L. J. Sedha</u>		24b. REGISTRAR'S SIGNATURE <u>L. J. Sedha</u>	
DATE <u>AUG 24 1956</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate must be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. B.

1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7940

CERTIFICATE OF DEATH

07911

Reg. Dist. No.

28

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 15 yrs., 25 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS None listed			
3 NAME OF DECEASED (Type or print) First Lillian Middle Thomas Last Thomas				4 DATE OF DEATH Month 8 Day 23 Year 19 56			
5 SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Not given		9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months - Days - Hours - Min -	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY - -		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME John Tregvan				14. MOTHER'S MAIDEN NAME Nancy Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Unk.		16. SOCIAL SECURITY NO. - -		17. INFORMANT Hospital Records			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion associated with arteriosclerotic DUE TO heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Several DUE TO (c) years				INTERNAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 7/29 , 19 56 , to 8/23 , 19 56 , that I last saw the deceased alive on 8/22 , 19 56 , and that death occurred at 4:30 a.m. , from the causes and on the date stated above.							
ACTUAL SIGNATURE L. Benediot				ADDRESS (Street, city or town, state) Crownsville, Maryland		DATE SIGNED 8/23/56	
PHYSICIAN'S NAME (Type) L. Benediot							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 8-28-56		22c. NAME OF CEMETERY OR CREMATORY Univ. of Md. Medical School		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23 FUNERAL DIRECTOR'S SIGNATURE William Case, Jr. - Annapolis, Md				24a. REC'D BY REGISTRAR 5-7 1956		24b. REGISTRAR'S SIGNATURE R. M. Gayer	

SEP 7 1956

BUREAU V. 2

7941

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East Port (Annapolis)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East Port (Annapolis)</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>401 Chester Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>B. A. I. N. E.</u> Middle <u>- O -</u> Last <u>T H O M P S O N.</u>				4. DATE OF DEATH Month <u>8</u> Day <u>31</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-17-1892</u>	9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cystrerman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-Employed</u>		11. BIRTH PLACE (State or foreign country) <u>Churchton, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wilson Thompson</u>				14. MOTHER'S MAIDEN NAME <u>Jane Matthews</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-16-3253</u>		17. INFORMANT <u>Ethel Thompson</u> Address <u>401 Chester Ave. Annapolis, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DROWNING</u> 975X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (u) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. Linhardt</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. LINHARDT</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>9/1/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>9-4-56</u>		<u>Franklin Chapel</u>		<u>Churchton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr.</u>				24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Wm. J. French</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. L.

SEP 7 1956

RECEIVED

may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07913

CERTIFICATE OF DEATH

Reg. Dist. No. 21

7881

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A. A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>VINCENT F. TREADWAY</u>		4. DATE OF DEATH <u>Aug. 13 1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 2, 1885</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gas and Elect. Co</u>	
11. BIRTHPLACE (State or foreign country) <u>Annapolis, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Treadway</u>		14. MOTHER'S MAIDEN NAME <u>Harriett Daley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>212-05-5586A</u>	
17. INFORMANT <u>Maude P. Treadway- Wife- same as # 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio-Vasc. Renal Disease</u> 742x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Central arteriosclerosis c Small elements</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/5</u> , 1956, to <u>8/13</u> , 1956, that I last saw the deceased alive on <u>8/15</u> , 1956, and that death occurred at <u>12:57 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Annapolis, Md</u> DATE SIGNED <u>8/14/56</u> ACTUAL SIGNATURE <u>Maurice Klawans</u> M.D. PHYSICIAN'S NAME (Type) <u>MAURICE F. KLAWANS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 16, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopkins Funeral Home</u> ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>Aug 16, 56</u> 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

RECEIVED

AUG 17 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

7882

CERTIFICATE OF DEATH

Reg. Dist. No. 2

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>415 Monterey Ave</u>		d. STREET ADDRESS <u>415 Monterey Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Nannie M. Wells</u>		4. DATE OF DEATH Month <u>August</u> Day <u>22</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 10, 1876</u>
9. AGE (In years last birthday) yrs <u>79</u>		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>J. Haddoway Mills</u>		14. MOTHER'S MAIDEN NAME <u>Malissa Hubbard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u> </u>	
17. INFORMANT <u>Ruth Jungers</u>		Address <u># 2</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) <u>per arteriosclerosis</u> DUE TO (c) <u>arteriosclerotic heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 10, 1949, to 8723, 1956, that I last saw the deceased alive on 8723, 1956, and that death occurred at 4:00 PM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) 20 Bonnell DATE SIGNED Amos Garrett Bourn

ACTUAL SIGNATURE S Bonnell M.D. Amos Garrett Bourn

PHYSICIAN'S NAME (Type) S Bonnell Amos Garrett Bourn

22a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>8-24-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green lawn</u>	22d. LOCATION (City, town, or county) (State) <u>Cambridge, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Layton & Sons</u>		24a. REC'D BY REGISTRAR DATE <u>8/24/56</u>	
ADDRESS <u>Annapolis, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>V. D. ...</u>	

MEDICAL CERTIFICATION

1976

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7942

Reg. Dist. No.

24

1. PLACE OF DEATH a. COUNTY <i>Anna Rundle</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>		c. LENGTH OF STAY IN 1b <i>20 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>22 New Jersey Ave</i>				d. STREET ADDRESS <i>22 New Jersey Ave</i>			
3. NAME OF DECEASED (Type or print) First <i>Theodore</i> Middle <i>A.</i> Last <i>Keneriski</i>				4. DATE OF DEATH Month <i>August</i> Day <i>3</i> Year <i>1956</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>April 1861</i>	
9. AGE (In years last birthday) <i>95</i> yrs.		IF UNDER 1 YEAR Months <i>95</i> Days <i>95</i> Hours <i>95</i> Min.		IF UNDER 24 HRS. Hours <i>95</i> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Poland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>							
13. FATHER'S NAME <i>Kolankiewicz</i>				14. MOTHER'S MAIDEN NAME <i>Eva Drankiewicz</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>22 New Jersey Ave</i>			
17. INFORMANT <i>Eva Drankiewicz</i>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute pulmonary edema</i> 44-1 DUE TO <i>arteriosclerotic Cardio-vascular disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>1-1/2 hrs.</i> (c) <i>15 yrs.</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour <i>19</i> a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>R. M. McLaughlin</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>R. M. McLaughlin, M.D.</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8/6/56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven</i>		22d. LOCATION (City, town, or county) (State) <i>A. A. Co. Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. S. Fialkowski</i>				ADDRESS <i>2007 Eastern Ave</i>		24a. REC'D BY REGISTRAR <i>24</i>	
				24b. REGISTRAR'S SIGNATURE <i>L. J. D. Alby</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

AUG 7 1906

RECEIVED

07917

21

CERTIFICATE OF DEATH

Reg. Dist. No.

7943

1. PLACE OF DEATH a. COUNTY <i>A. A.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Ind</i> b. COUNTY <i>A. A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <i>St Margarets</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>St Margarets</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>Louise Virginia Wright</i>		4. DATE OF DEATH <i>Aug 31 1956</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar. 22 1871</i>
9. AGE (In years last birthday) <i>85</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>St Margarets</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>John W. Barnes</i>		14. MOTHER'S MAIDEN NAME <i>Annie Blansbury</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Agnes Wright</i>		Address <i>1609 Baltimore Ave</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> <i>443X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Hypertension</i> DUE TO (c) <i>vascular disease</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>August 17, 1956</i> to <i>August 31, 1956</i> that I last saw the deceased alive on <i>August 31, 1956</i> , and that death occurred at <i>2:00 P. M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>R. H. Richardson</i>		ADDRESS (Street, city or town, state) <i>110 - Clay St Annapolis Md</i>	
PHYSICIAN'S NAME (Type) <i>R. H. RICHARDSON MD</i>		DATE SIGNED <i>8/1/56</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>	22b. DATE THEREOF <i>Sept. 2/56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Broadneck</i>	22d. LOCATION (City, town, or county) (State) <i>St Margarets Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Annie H. Johnson</i>		ADDRESS <i>Annapolis</i>	
24a. REC'D BY REGISTRAR <i>W. J. French</i>		24b. REGISTRAR'S SIGNATURE <i>W. J. French</i>	
DATE <i>5</i>		1956	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF CALIFORNIA

1111

BUREAU V. 2

SEP 5 1956

RECEIVED

7944

CERTIFICATE OF DEATH

07918

Reg. Dist. No. 25

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		MARYLAND		STATE Maryland		COUNTY Anne Arundel	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Brooklyn Park		LENGTH OF STAY (in this place) 3 yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brooklyn Park			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 104 Hilltop Road				STREET ADDRESS (If rural give location) 104 Hilltop Road			
3. NAME OF DECEASED (Type or Print) WILLIAM JOSEPH YERBY				4. DATE OF DEATH (Month) (Day) (Year) August 9, 1956			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH June 27, 1886	9. AGE last birthday 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10b. KIND OF BUSINESS OR INDUSTRY Laurel Races		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Robert Yerby				14. MOTHER'S MAIDEN NAME Mary J. Duffy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Marie Yerby 104 Hilltop Rd.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
331x IMMEDIATE CAUSE (A) Cerebral Hemorrhage						INTERVAL BETWEEN ONSET AND DEATH 10 days	
ANTECEDENT CAUSE(S) DUE TO (B) Arterio-sclerosis - Hypertension						5 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> el work <input type="checkbox"/> el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 9, 1956</u> to <u>Aug 9, 1956</u> , that I last saw the deceased alive on <u>Aug 9, 1956</u> , and that death occurred at <u>8:45 PM</u> , from the causes and on the date stated above.							
SIGNATURE Chas. L. Ball				DATE SIGNED 203 W. Maple Road Linthicum Aug. 10			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Aug. 13, 1956		NAME OF CEMETERY OR CREMATORY Cathedral Cn.		LOCATION (City, town, or county) (State) Baltimore, Md.	
24. REC'D BY REGISTRAR DATE AUG 15 1956		REGISTRAR'S SIGNATURE She Watson		25. FUNERAL DIRECTOR'S SIGNATURE George J. Gonce		ADDRESS 4001 Ritchie Hgw	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 104

CERTIFICATE OF DEATH

DEATH
PLACE
DATE

DEATH
PLACE
DATE

RECEIVED

BUREAU V. S.

AUG 15 1956

RECEIVED